



Admission Application

801 North Hanover Street • Carlisle, PA 17013
Phone: (717) 249-5322 • Fax: (717) 249-8622

www.churchofgodhome.org

If you need assistance with this application, please contact us directly. Thank you!

The Church of God Home, Inc. agrees that this application is confidential and will be used for processing purposes only. The information is applicable for all levels of care offered by the Church of God Home community. The Church of God Home, Inc. is in compliance with all federal HIPAA requirements and admits and treats all persons without regard to race, color, national origin, age, ancestry, sex, handicap, disability or religious creed.

I. Applicant Information *(please print or type)*

- 1.) Name _____
- 2.) Current Location
 Hospital Rehab Center Psychiatric Unit
 Other Nursing Home Community Living
- 3.) Facility Name _____
- 4.) Home Address _____
City _____ State _____ Zip _____ Phone (____) _____
- 5.) Date of Birth _____ Birth Place _____
- 6.) Marital Status _____ Name of Spouse _____
- 7.) Church _____
City _____ Pastor _____ Phone (____) _____
- 8.) Funeral Home _____ City _____ Phone (____) _____
- 9.) Cemetery Name _____ # Spaces Owned _____
City _____ State _____ Zip _____
- 10.) Burial Reserve set up with Bank or Funeral Home? Yes No Amount \$ _____
- 11.) Ambulance Coverage? Yes No Company Name: _____
- 12.) Veteran Status Self Spouse Branch: _____

II. Medical Profile

- 1.) Physician _____ Address _____
City _____ State _____ Zip _____ Phone (____) _____
- 2.) Diagnosis/Physical Disability _____
- 3.) Hospital Preference _____
- 4.) Has applicant ever resided in another nursing home? Yes No How long? _____
In the last one (1) month? Yes No In the last six (6) months? Yes No
- 5.) Has applicant received in-patient psychiatric care in the past two (2) years? Yes No
- 6.) Has applicant executed Healthcare Guidelines/Living Will? Yes No
- 7.) Has applicant executed a Personal Will? Yes No
- 8.) Name of Executor _____
Address _____
City _____ State _____ Zip _____
Phone: Work (____) _____ Home (____) _____ Cell (____) _____
- 9.) Is applicant a U.S. Citizen? Yes No
- 10.) Applicant anticipates placement to be: Short Term Long Term Undecided

III. Health Insurance

- 1.) Social Security # _____ PACE CARD Yes No
- 2.) Medicare # _____ Part A _____ Effective Date _____
Part B _____ Effective Date _____

3.) Health Insurance Co. Name _____ I.D. # _____ Group # _____

4.) Long Term Health Insurance Co. Name _____ I.D. # _____

5.) Department of Welfare Access Card # _____

IV. Contact Persons/Power of Attorney

1.) Has applicant executed a Power of Attorney? Yes No Is it durable? Yes No

2.) Does it cover Healthcare Issues? Yes No

3.) Power of Attorney's Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: (Work) (____) _____ (Home) (____) _____ (Cell) (____) _____

4.) Does applicant have a court appointed Legal Guardian? Yes No

5.) Legal Guardian Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: (Work) (____) _____ (Home) (____) _____ (Cell) (____) _____

6.) Secondary Contact Person Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: (Work) (____) _____ (Home) (____) _____ (Cell) (____) _____

Financial Profile

1.) Billing Information:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: (Work) (____) _____ (Home) (____) _____ (Cell) (____) _____

2.) Income

Amount Per Month

Joint Account

Social Security \$ _____ Yes No

Supplemental Security Income \$ _____ Yes No

Veterans Benefits \$ _____ Yes No

Public Assistance \$ _____ Yes No

Pension \$ _____ Yes No

Annuity \$ _____ Yes No

Trust \$ _____ Yes No

Rental \$ _____ Yes No

Dividends \$ _____ Yes No

Interest Earnings \$ _____ Yes No

Bonds \$ _____ Yes No

Other Sources \$ _____ Yes No

_____ \$ _____ Yes No

Total Monthly Income \$ _____

3.) Assets

Checking Accounts:

Currents Balances

Joint Account

A. Bank _____ \$ _____ Yes No

B. Bank _____ \$ _____ Yes No

Savings Accounts:

A. Bank _____ \$ _____ Yes No
B. Bank _____ \$ _____ Yes No

Real Estate:

Type	Location	Appraised Value	Jointly Owned
A. _____	_____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. _____	_____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is any property jointly owned? Who is co-owner?

Name _____ Relationship _____

Other sources of Income: Total Value Jointly Owned

Certificates of Deposit _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mutual Funds _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Stocks and Bonds _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Other Assets (please specify)

Life Insurance Policies (on applicant's life, or owned by applicant)

Company	Policy No.	Face Value	Cash Value
A.) _____	_____	_____	_____
B.) _____	_____	_____	_____

4. Liabilities

Any debts, mortgages, credit cards, obligations, etc., affecting income or interest assets:

		Joint Account
_____	Balance \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Balance \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Balance \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

5.) Health Insurance Premiums Per Month Per 1/4 Amount \$ _____

6.) Have any assets, real estate or personal property been transferred to anyone or any entity in the past three (3) years? Yes No In the Past five (5) years? Yes No

If yes, to whom was it transferred?

Name _____ Relationship _____

Address _____ Phone (Work) (____) _____

City _____ State _____ Zip _____ Phone (Home) (____) _____

Value of amount transferred? Amount \$ _____

7.) Have Living Trusts been established in the last five (5) years? __Yes __No

If yes, are these funds available for applicant's care? __Yes __No

Value in trust: Amount \$ _____

Names of Trustee(s) _____

IV. Level of Care/Housing Preference

Nursing Care

Assisted Living

Independent Living

"LeTort Manor"

Private Room

Studio Apartment

Apartment "A"

Semi-Private Room

One Bedroom Apartment

Apartment "B"

Respite Care

Private Room

Apartment "C"

Semi-Private Room

Apartment "D"

Respite Care

Apartment "E"

Acknowledgment

I/we understand that the Church of God Home reserves the right to accept or reject any application consistent with the law. I/we certify that all of the information submitted on this application is true and correct and that submission of false information may constitute grounds for rejection of the application and discharge after admission.

Note: Nursing and Assisted Living applications will be on file for three (3) years.

For LeTort Manor Applicants Only

Along with the completed application form, I/we have enclosed an application fee of one thousand dollars (\$1,000.) This fee will assure my/our position among prospective residents in choosing the type of apartment and location I/we desire. It will be applied toward my/our entrance fee. The fee will be fully refunded should I/we withdraw the application for any reason.

I/we further understand that within thirty (30) days of a request from the Church of God Home, I/we shall sign the Residence and Care Agreement and complete the initial installment of the entrance fee in the amount of Ten Thousand dollars (\$10,000) and will be asked to pay the balance due prior to move-in. The failure to sign the Residence and Care Agreement and make the required payments may constitute grounds to terminate this agreement and will result in the release of the apartment unit reserved under this agreement, and the loss of my/our position on the waiting list for the reservation of an apartment unit, and the loss of any claims or right to occupy an apartment unit.

I/we accept and agree to the above conditions

Applicant's signature(s) _____

Date _____

I/we accept and agree to the above conditions.

Signature of Applicant

Signature of Applicant #2

Signature of Person Completing Application / Relationship to Applicant

Date