SJLC Use Only
Date completed application received: _____

Application for Admission

Personal/Family		
Applicant's Full Name:	Social Security #:	Telephone #:
Street Address: Number of years at this address:	Previous Address:	
Date of Birth:	Marital Status:	Sex:
Name of Alternate Contact:		Relationship:
Address:		Telephone:

Medical/Social

Presently Living at:

☐ Home Alone ☐ Nursing Home ☐ Independent or Assisted Living
☐ Home with family ☐ Hospital ☐ Other:

Name of Primary Care Physician:

Current Diagnoses:

Does the Applicant have any infections and /or communicable diseases?
Yes ☐ No ☐ Explain:

Brief Description of Applicant's recent Health History:

Receiving Community Services?
Yes☐ No ☐

Agency Name:
Contact Name:
Phone:

Height:	Weight:

Any Psychiatric History or Abnormal Behavior Patterns?
Yes ☐ No ☐ Explain:

Previous stay at a long-term care facility? Yes ☐ No ☐
Name of Facility: _____
Dates: _____

We require that your PCP completes the enclosed Medical Profile packet

Advance Directive	
Living Will? Yes ☐ No ☐ Health Care Agent? Yes ☐ No ☐	Power of Attorney? Yes ☐ No ☐ Conserved? Yes ☐ No ☐
Person managing/assisting with applicant's funds: Name: _____ Phone: _____ Email: _____	

We require copies of all advanced directive documents. Copies can be made at the facility for no charge.

Insurance Information		
Medicare #:	Medicare Advantage Plan: #:	Medicaid #:
Medicare #: Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐ Part D: Yes ☐ No ☐	LTC Insurance Plan: #:	
Medicaid Pending as of:	DSS Case Worker's Name & Phone #	
Veteran? Yes ☐ No ☐	Spouse of Veteran? Yes ☐ No ☐	

We require copies of an ID and all insurances/benefit cards and a copy of T-19 app if T-19 is pending prior to admission. Copies can be made at the facility at no charge.

Income Source	
Social Security $	Benefits #
VA Benefits $	Benefits #
Pension (company) $	Benefits #
Pension (company) $	Benefits #
Pension (company) $	Benefits #

SSI $	Benefits #
CD's $	Benefits #
Annuities $	Benefits #
Dividends $	Benefits #
Interest $	
Other Income $	
Do you receive income from or have any interest in any trusts? Yes ☐ No ☐ If yes, a copy of the trust instrument is required.	

Bank Account(s)			
Name of Bank	**Name(s) on Account**	**Type of Account**	**Balance**

Please provide 3 months of bank statements including Bank Books.

Real Estate			
Type of Real Estate	**Where Located**	**Ownership Name**	**Est. Value**

List any liens, mortgages, or reverse mortgages against the property.	Amount? $	Payable to?

Is anyone living at the property aside from the applicant? Yes ☐ No ☐	Who?	Relationship?

Type of Real Estate	**Where Located**	**Ownership Name**	**Est. Value**

List any liens, mortgages, or reverse mortgages against the property.	Amount? $	Payable to?
Is anyone living at the property aside from the applicant? Yes ☐ No ☐	Who?	Relationship?
Does the applicant have a burial contract? Revocable ☐ Irrevocable ☐ None ☐ If yes, then complete below:		
Name of Funeral Home:		
Cemetery Plot	Amount	

Other Assets	
i.e. Stocks, Bonds, Mutual Funds, IRA, etc.	
Item	Amount $
Item	Amount $
Item	Amount $
Item	Amount $

Life Insurance
Does the applicant have life insurance? Yes ☐ No ☐ Please provide copies of life insurance policies.

Transfer of Assets		
Has the applicant sold or transferred any motor vehicles, property, stocks, bonds, cash or other significant assets (valued 500 or more) in the past 60 months? Yes ☐ No ☐		
Amount Transferred	To Whom?	Reason
$		
$		
$		
$		
$		

Required additional documents:

- ☐ Medical Profile Packet (Completed by PCP)
- ☐ Current Medication List
- ☐ History and Physical (dated within the last 30 days)
- ☐ Face sheet
- ☐ Nurses' notes, Psych notes, Consult notes (if applicable)
- ☐ Advanced Directives (including but not limited to POA, Conservator, Living Will, Healthcare Agent)
- ☐ Photo ID
- ☐ All Insurance/benefits cards
- ☐ Trusts
- ☐ 3 months of statements from all bank accounts
- ☐ Life Insurance
- ☐ T-19 Application (If Medicaid Pending)

I hereby certify that this is a true and complete statement of my current income, assets, any gifts, transfer of assets, and/or transfer of assets to an irrevocable trust within the last 60 months prior to the date of this application.

_____	_____
Applicant's Signature or Mark (X)/Date	Witness' Signature if signed with an X
_____	_____
P.O.A., Conservator, Durable Power of Attorney	Responsible Party

_____	_____	_____
Date	Phone #	E-Mail