

**Lutheran SeniorLife
Passavant Retirement Community**

Directions for Application Packet

Please answer every question on the application in full. All forms must have a signature for the applicant or person with Power of Attorney.

Note: Husband and wife must submit separate applications and separate questionnaires; however, one financial application may be submitted unless the finances are kept separately.

Please submit the following information prior to admission:

1. Completed application for admission
2. Notarized financial application
3. Copies of proof of assets (checking and savings account statements, CD's, stocks, etc.)
4. Copy of Durable Power of Attorney
5. Copies of Medicare card (front only), secondary insurance cards (front and back), other primary insurance cards (front and back), and Social Security card (front only)
6. Current photograph
7. Return completed application with a check made payable to Passavant Retirement Community in the amount of \$750.00 (one person), \$1,000 (two persons). \$250.00 each is a non-refundable processing fee. \$500.00 is completely refundable. It will be credited towards the entrance fee for the unit or returned with a written request.
8. Please mail the completed application, necessary forms above, and form of payment to:

Passavant Retirement Community
401 South Main Street
Zelienople, PA 16063
Phone: (724) 452-5400

Lutheran SeniorLife Passavant Retirement Community

RESIDENTIAL LIVING APPLICATION FOR ADMISSION

Name of Applicant: _____
Last First Middle

Address: _____
Street/Box No. Apt. County

City State Zip Telephone No. _____

Summer/Winter: _____
Address: Street/Box No. Apt. County

City State Zip Telephone No. _____

Date of Birth: _____ Place of Birth: _____

Social Security No.: _____ Medicare No.: _____

PACE # (if applicable): _____

Other Prescription Coverage: _____

Blue Cross Agreement #: _____ Group #: _____

Blue Shield Agreement #: _____ Plan Code: _____

Other Hospitalization: _____

Veterans Serial Number: _____

Marital Status: M S W D Sep
(Circle one)

Name of Spouse: _____

If living, Address: _____

If deceased, date: _____

Person holding Durable Power of Attorney (Please include a copy)

Name Relationship

Address Phone Home: _____

Address Phone Work: _____

Cell Phone: _____

It is strongly recommended that each resident appoint a Durable Power of Attorney and designate your wishes through a Living Will prior to admission.

Emergency Contacts:

Note: The facility will contact one person in an emergency. In turn, that person is responsible for contacting alternate contacts.

Primary Contact:

Name Phone Home: _____
Phone Work: _____
Cell Phone: _____

Address Relationship

Alternate Contacts:

Name Phone Home: _____
Phone Work: _____
Cell Phone: _____

Address Relationship

Alternate Contacts:

Name Phone Home: _____
Phone Work: _____
Cell Phone: _____

Address Relationship

Person to Receive Billing Statement: Name: _____

_____ Phone Home: _____

Address

_____ Phone Work: _____

Address

Cell Phone: _____

Physician: _____ Phone: _____

Address: _____

Church Affiliation:

Name: _____ Pastor: _____

Address: _____ Phone: _____

Funeral Director:

Name: _____ Phone: _____

Address: _____

Cemetery and Lot No.: _____

Who holds the deed? _____

Date of Desired Admission: _____

Date

x

Signature

Facility Use Only: Referral Source: _____

Name: _____ Date: _____

Prefer to be called: _____

So that we may become better acquainted with you, we are requesting the following sheet be completed.

1. Where did you grow up? In the city _____ In the country _____ In Suburbs _____

2. Education: High School _____
College _____ Degree _____
Additional Courses _____ Degree _____

3. Occupation _____
Where were you employed? _____

4. Church Affiliation? _____

5. In what church activities are you interested? _____

6. In what community organizations have you been active? _____

7. Did you ever receive any distinguished honors? _____

8. Where have you traveled? _____

9. What are your hobbies and interests? _____

10. Do you anticipate participating in Community's activities? _____

11. How many children do you have? _____

12. List any other information which you feel is important for us to know about you.

Name _____ Date _____

Please complete this information sheet and return with your application.

- | | YES | NO | |
|-----|-------|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | _____ | _____ | Do you drive a car? |
| 2. | _____ | _____ | Do you do your own shopping for groceries?
If no, who helps you? _____ |
| 3. | _____ | _____ | Do you do your own cooking?
If no, who helps you? _____ |
| 4. | _____ | _____ | Do you presently do your housework?
If no, who helps you? _____ |
| 5. | _____ | _____ | Can you dress yourself completely?
If no, who helps you? _____ |
| 6. | _____ | _____ | Can you bathe yourself in a tub or shower?
If no, who helps you? _____ |
| 7. | _____ | _____ | Do you take care of your own finances?
If no, who helps you? _____ |
| 8. | _____ | _____ | Do you use a cane or crutches?
If no, who helps you? _____ |
| 9. | _____ | _____ | Are you confined to a wheelchair?
If no, who helps you? _____ |
| 10. | _____ | _____ | Can you walk up one flight of stairs without stopping? |
| 11. | _____ | _____ | Can you walk one average city block without
stopping? |
| 12. | _____ | _____ | Do you get depressed easily? |
| 13. | _____ | _____ | Have you ever received treatment as an in-patient or
out-patient for depression or any other psychiatric
problems? |
| 14. | _____ | _____ | Did you decide to come to Passavant? |
| 15. | _____ | _____ | Are you coming here because your family desires you
to have the care that Passavant Retirement Community
offers? |
| 16. | _____ | _____ | How frequently do you see your doctors?
_____ Every two weeks _____ Monthly
_____ Once a year _____ Twice a year |
| 17. | | | Have you ever received a pneumonia vaccine? _____ Date: _____
Have you ever received a flu shot? _____ Date: _____
Have you received Mantoux (Tuberculosis) _____ Date: _____ |

**Passavant Retirement Community
Financial Application**

Date _____

Name _____

Street _____ Box # _____ Apt. # _____

City _____ State _____ Zip _____

STATEMENT: Each resident who is admitted must give evidence of his/her ability to pay. Each resident must represent and warrant that no action has been, or will be taken to dispose of, or transfer any assets for less than fair market value, or take any other action, or inaction, which would disqualify the resident for governmental or third party assistance programs.

I. INCOME: (Please declare all monthly income).

SOURCE:	AMOUNT PER MONTH		
	Husband	Wife	Single
Social Security	\$ _____	\$ _____	\$ _____
Pension	\$ _____	\$ _____	\$ _____
Dividends and Interest	\$ _____	\$ _____	\$ _____
Rental/Mortgage Income	\$ _____	\$ _____	\$ _____
Trust Income	\$ _____	\$ _____	\$ _____
Other Income (please specify)	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____
TOTAL	\$ _____	\$ _____	\$ _____

Explain any change in the event of either spouse's death:

Life Insurance Policy: (Applicant #1)

Name of Beneficiary: _____ Value: _____

(Applicant #2)

Name of Beneficiary: _____ Value: _____

Long Term Care Policy:

Carrie & Number _____

II. **ASSETS:** Please declare all assets. (Assets refer to anything that is not monthly income.)

TYPE	VALUE
Checking	\$ _____
Savings	\$ _____
Stocks, Bonds, Certificates	\$ _____
Real Estate	\$ _____
Other	\$ _____
TOTAL	\$ _____

III. **LIABILITIES:** (Please declare all liabilities that would infringe upon your ability to pay for your care at this facility.)

TYPE	VALUE
Mortgage Payments	\$ _____
Notes Payable	\$ _____
Notes Endorsed	\$ _____
Personal Debts	\$ _____
TOTAL	\$ _____

Have you transferred any real or personal property in the past five years? Yes No
 If so, please explain:

Have you made any gifts of money or securities in the past five years? Yes No
 If so, please explain:

I hereby attest that the information stated herein is true and correct. I hereby agree that prior to my move to the facility and each year thereafter, I will submit an updated financial application.

 Witness

 Applicant

 Witness

 Applicant

Affadavit

State of _____:

SS.

County of _____:

On this, the _____ day of _____, 20____, before me, a Notary Public, the undersigned officer, personally appeared _____ known to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes there contained, IN WITNESS WHEREOF. I hereunto set my hand and official seal.

Notary Public _____ My Commission Expires: _____