APPLICATION FOR ADMISSION

Please check the appropriate program:
- ◯ Heritage Manor, Skilled Nursing Care
- ◯ Southgate Special Care, Skilled Nursing Care
- ◯ Longview, Premier Assisted Living
- ◯ Hillcrest, Independent Living Plus

Referred by: _____

How did you hear about Christian Health?

___ Newspaper ad (newspaper: _____)
___ Newspaper article (newspaper: _____)
___ Church bulletin (church _____)
___ Social worker (name _____)
___Friend/word of mouth
___Christian Health website
___Christian Health publication
___Physician (name_____)

I. General information regarding prospective resident

A. Applicants name _____ Preferred Name/Nickname _____
Pronouns He/Him/His _____ She/Her/Hers _____ They/Them/Theirs _____
Gender assigned at birth Male _____ Female _____ Intersex _____
What is your current gender identity? _____
Home address _____
City_____ County _____ State_____ Zip _____
Home telephone # _____ Cell # _____ Email: _____
Applicants date of birth _____ Age _____ Social Security # _____
Marital Status _____ Spouse's Name _____
Applicant is currently at home ___ hospital ___ nursing home ___ other ___ How long?___
Please identify location: _____
Applicant's birthplace* _____ Is the applicant a US citizen? Yes ___ No ___
*Please provide citizenship papers if applicant was born outside of the United States
Is the applicant a veteran? Yes ___ No ___ Branch of service _____
Primary language: English _____ other _____
Is the applicant currently employed? Yes ___ No ___ Employed with _____
Education _____ Past occupation _____
Religion _____ Church/town _____ Pastor _____

Room preference: Private ___ Shared ___ Hospital preference _____
Is the applicant aware of this application and agreeable to moving? Yes ___ No ___
Can the applicant be contacted regarding status of the application? Yes ___ No ___
If applicant still drives and will have a vehicle here, please provide the following:
Make _____ Model _____ Year _____ License Plate # _____
Is the applicant currently a smoker? Yes ___ No ___
(NOTE: Christian Health is a smoke free facility)

B. Financial guarantor (person to whom Christian Health will send financial invoices)

Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____
Occupation _____
****What person or firm holds financial power of attorney? (copy required)**
Name _____ Telephone # _____

Emergency contact (Person to contact for emergencies and all issues care related)

Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____
Occupation _____

Medical power of attorney/durable power of attorney (copy required)

Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____
Occupation _____

Mailings (person will receive all mailings and email from Christian Health [excluding financial invoices], newsletters, invitations to events, etc)

Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____

Next of kin (not listed above)

1. Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____

2. Name _____ Relationship to applicant _____
Address _____
City _____ County _____ State _____ Zip _____
Home telephone # _____ Business # _____ Cell # _____
Which number is best to reach you? _____ Email _____

II. Medical & Clinical Information

A. Advanced Directives

Does the applicant have written advance directives for life-sustaining treatment or Physician's Orders for Life Sustaining Treatment (POLST)? Yes ___ No ___
A current Do Not Resuscitate (DNR) order by a physician? Yes ___ No ___
If yes, copies are required with the application.

B. Applicant's physician (Please list all attending physicians)

Physician Name & Specialty	*Telephone*	*Fax*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Funeral/burial arrangements:

1. Name of funeral home _____
Address _____ Telephone # _____
Name of cemetery _____
Address _____ Telephone # _____
Are the arrangements prepaid? Yes ___ No ___
If yes, which type of trust account were they placed in? Revocable ___ Irrevocable ____

2. Organ donation: Yes ___ No ___ (if yes, please provide copy of organ donation card)

D. Clinical Documentation

**Each program requires individual supporting clinical documentation you will be asked to supply prior to admission.

E. Health Insurance Information

**Please provide copies (front & back) of all health insurance, prescription cards, PAAD.

F. Medicaid (ONLY Heritage Manor and Southgate Special Care)

Is the applicant a Medicaid recipient? Yes ___ No
If yes, Medicaid # _____ Effective date _____

If no, has the applicant applied for Medicaid or public assistance? Yes ___ No ___
If yes, county of application _____ Date of application _____
Application status _____ Caseworker name _____ Telephone _____

III. Financial Information (*Please list all assets currently* ***IN THE APPLICANT'S NAME*** *that will be used to pay for care at Christian Health. Provide documentation to support all listed assets.*

NOTE: this section does not apply to residents of The Vista.

Monthly Income	**Gross**	**Net**
Social Security		
Pension		
Veterans benefit		
Alimony		
Estates/trusts		
Rent		
Interest		
Dividends		
Salary		
Other Income		
Sub-total income (net only)		
Cash assets	**Date balance reflects**	**Balance in account**
Checking		
Savings		
CDS		
Securities (stocks/bonds)		
Life insurance cash value		
Other		
Sub-total cash assets		
Real estate		
Value of home		
Value of additional property		
Sub-total real estate values		
Debt	**Subtract all debt from available assets**	
Loans (home equity, personal, etc)		
Credit cards		
Mortgages		
Outstanding medical expenses		
Other		
Sub-total debt		( )
Total available assets for use at Christian Health		

IV. Financial questionnaire

Will the applicant pay for care with their own funds? Yes ___ No ___

Does the applicant own a home, timeshare or any other property? Yes ___ No ___
If yes, specify location and/or lot/block number _____

*Is the home, timeshare or any other property currently for sale? Yes ___ No ___
*If yes, will the proceeds be used to pay for the applicant's care? Yes ___ No ___

Are there any residence(s) jointly owned? Yes ___ No ___

Please list spouse or children currently living in home: _____

Did the applicant own a home (not already listed) in the last 15 years? Yes ___ No ___
If yes, what was the disposition of the home? _____

Does the applicant have a disabled child who is currently receiving Social Security Disability Insurance benefits? Yes ___ No ___

Have any assets been transferred in the last 60 months? Yes ___ No ___
If yes, please describe: _____

Have there been gifts or loans for no consideration in the last 60 months? Yes ___ No ___
If yes, please list: _____

Have any trusts been established during the last 60 months? Yes ___ No ___
If yes, please describe (***copy required***): _____

Are there any pending lawsuits, settlements, accident claims, inheritance claims, or does anyone owe money to the applicant? Yes ___ No ___
If yes, please describe: _____

V. Certification

- According to the best of my knowledge, the information provided in section I through II is accurate and true in all respects.
- I understand no application is considered for admission until all requested information and supporting documentation is provided.
- I certify that all assets listed on the financial page will be used for the care and treatment of the applicant. I understand that divestiture of funds, gifting, etc of any reported assets may jeopardize future Medicaid eligibility and/or continued residence at Christian Health.
- I agree, if admitted, to abide by the regulations and policies of Christian Health.
- I understand that a security deposit and advance payment is required prior to the day of admission, based on the specific requirements of the program.
- I agree, if admitted, to pay for a bed reserve (equal to the per diem room rate) for the day(s) between my formal commitment to accept a room at Christian Health and the actual day of physical admission. The foregoing requirement for payment does not apply to a prospective Heritage Manor or Southgate Special Care applicant determined to be eligible for Medicaid upon admission.

_____ **and/or** _____

Signature of applicant — Signature of person acting for applicant

_____ _____

Date — Date

_____

Address

_____

Telephone

_____

Relationship to applicant

Christian Health respects all religious faiths. Applicants have equal opportunity for admission without regard to race, color, creed, national origin, age, sex, religion, disability, payment source, marital status, sexual orientation (LGBTQI+) or veteran status.