



## **RESIDENTIAL LONG-TERM CARE & ELDER SERVICES**

### **APPLICATION FOR RESIDENCE**

Holy Redeemer St. Joseph Manor  
1616 Huntingdon Pike  
Meadowbrook, PA 19046

Holy Redeemer Lafayette  
8580 Verree Road  
Philadelphia, PA 19111

Skilled Nursing Facility  
Phone (215) 938-4057  
Fax (215) 938-4084

Skilled Nursing Facility  
Phone (215) 214-2846  
Fax (215) 214-2849

Personal Care  
Phone (215) 938-4060  
Fax (215) 938-4103

Independent Living Leasing Office  
Phone (215) 214-2877  
Fax (215) 745-6713

[www.holyredeemer.com/lifecare](http://www.holyredeemer.com/lifecare)

**APPLICATION FOR RESIDENCE**

For Office  
Use Only  
\_\_\_ ALU  
\_\_\_ LTC  
\_\_\_ IND

Name of Applicant: \_\_\_\_\_  
(Last) (First) (Middle)

Current Address: \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Does Applicant Own: Yes No Does Applicant Rent: Yes No

Applicant's telephone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other Names / Maiden Name of Applicant: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Name of Spouse: \_\_\_\_\_  
(Last) (First) (Middle)

Current Address: \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Does Spouse Own: Yes No Does Spouse Rent: Yes No

Spouse's telephone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other Names / Maiden Name of Spouse: \_\_\_\_\_

If spouse is deceased, Date of Spouse's death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Children & Family Relations**

1.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

2.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

3.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

Applicant's Religious Affiliation / Wishes: \_\_\_\_\_

Name of Applicant's Church/Synagogue: \_\_\_\_\_

**PLEASE PROVIDE COPIES OF INSURANCE CARDS (front and back)**

Primary Insurance # \_\_\_\_\_  Medicaid # \_\_\_\_\_

Secondary Insurance # \_\_\_\_\_

AARP # \_\_\_\_\_  Health Insurance # \_\_\_\_\_

PACE # \_\_\_\_\_  Part D/Other Insurance # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ (Full Name)

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_

**Emergency Contacts**

1.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

2.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

3.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

**Power of Attorney – General / Financial** (Applicant must provide copy of POA)

Applicant's Agent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

Applicant gives permission to Holy Redeemer Health Systems to release any and all information regarding Applicant to \_\_\_\_\_.

**Healthcare / Power of Attorney – Medical** (Applicant Must provide Copy of POA)

Applicant's Agent's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: \_\_\_\_\_  
(Home) (Work) (Mobile)

Applicant gives permission to Holy Redeemer Health Systems to release any and all information regarding Applicant to \_\_\_\_\_.

**Advanced Medical Directives** (Applicant Must provide Copy of Healthcare Directive)

Has the Applicant executed an Advance Directive/ Living Will?  Yes  No  
(If yes, Applicant must provide a complete copy of the document to the facility)

**Burial Arrangements** (Applicant must provided copy of burial information to facility)

Funeral Director: \_\_\_\_\_ Amount of Pre-paid Funeral \$ \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cemetery: \_\_\_\_\_

Does Applicant have burial bank account: Yes No Date Established \_\_\_\_\_

Name of bank holding burial account: \_\_\_\_\_

Amount of funds in burial account: \$ \_\_\_\_\_ as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**LAST WILL & TESTAMENT:** Date Document signed by Applicant: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Location of Original Will: \_\_\_\_\_

Executor's Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Executor's Address: \_\_\_\_\_

Executor's Phones: \_\_\_\_\_  
(Home) (Work) (Cell / Mobile)

Applicant's Lawyer Name & Address: \_\_\_\_\_

Applicant's Lawyer Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Applicant's Accountant Name & Address: \_\_\_\_\_

Applicant's Accountant Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Applicant's Financial Planner Name & Address: \_\_\_\_\_

Applicant's Financial Planner Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## **Confidential Financial Statement**

Copy of most recent statement (s) required with application

### **Present Monthly Income** (proof of income required)

	(Self)	(Spouse/ Other)
Social Security	\$ _____	/ _____ /month
Supplemental Security Income	\$ _____	/ _____ /month
Pension	\$ _____	/ _____ /month
401-K & IRA Distribution	\$ _____	/ _____ /month
Rental Income	\$ _____	/ _____ /month
Interest & Dividends	\$ _____	/ _____ /month
Other ( _____ )	\$ _____	/ _____ /month

### **Financial Information** (if jointly owned/ titled, please note same with "Joint")

[1] Checking: \$ \_\_\_\_\_ Savings: \$ \_\_\_\_\_ CD: \$ \_\_\_\_\_

Money Market: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Account Number: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Account Number: \_\_\_\_\_

**[2] Stocks/Bonds: \$ \_\_\_\_\_ Life Insurance (cash value): \$ \_\_\_\_\_**

Name of Brokerage: \_\_\_\_\_

**[3] Real Estate Address: \_\_\_\_\_**

Market Value: \$ \_\_\_\_\_ Tax Assessment Value: \$ \_\_\_\_\_

Name of owner(s) on Deed: \_\_\_\_\_

Mortgage Debt balance \$ \_\_\_\_\_ as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Credit/ Other Debt balance \$ \_\_\_\_\_ as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Liens or Judgments: ""Yes ""No ""Amount of Liens & Judgments: \$ \_\_\_\_\_

**[4] Annuity & Insurance: Name of Annuity / Insurance Company: \_\_\_\_\_**

Account / Policy # \_\_\_\_\_

Face Amount \$ \_\_\_\_\_ Cash Surrender Value \$ \_\_\_\_\_ as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_aa

Owner Name: \_\_\_\_\_ Beneficiary Name: \_\_\_\_\_

Loans against annuity or policy \$ \_\_\_\_\_ Maturity Date: \_\_\_\_\_

**Other Total Assets: \$ \_\_\_\_\_ (Describe on separate page)**

**Other Total Outstanding Liabilities: \$ \_\_\_\_\_ (Describe on separate page)**

**Holy Redeemer Health System requires each Applicant/Resident & their Spouse to submit copies of Federal Income Tax Returns for five (5) tax years prior to the Applicant's date of admission to the facility.**

I/ We verify the information on this *Application for Residence* is true and correct and, I/We understand Holy Redeemer Health System will rely on said information provided by us in forming a business relationship with us for the provision of the necessary services requested by us for the Applicant.

I/ We shall provide copies of all financial and other information requested above, within seven (7) days of the date of this Application for Residence.

I/ We agree to apply for Department of Public Welfare, Medical Assistance, Nursing Home Care, benefits when I/We know our total assets are equal or less then \$25,000 or when requested by Holy Redeemer Health System to submit an application for Department of Public Welfare benefits. I/We understand that it is our responsibility to apply for and obtain Department of Public Welfare, if necessary, to pay for the necessary services provided to the Applicant. I/We authorize Holy Redeemer Health System to assist the Applicant, when able, in obtaining Department of Public Welfare benefits. I/ We understand Holy Redeemer Health System is not obligated to assist **the** Applicant in obtaining benefits and, the Applicant releases and holds Holy Redeemer Health System harmless in the event the Applicant is determined, for any reason, not to be eligible for benefits.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Power of Attorney Signature)

\_\_\_\_\_  
(Print Name of Applicant's Power of Attorney)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant Spouse Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Spouse's Power of Attorney Signature)

\_\_\_\_\_  
(Print Name of Applicant's Spouse's Power of Attorney)