STATUS _____/_____
A.D. _____
MR# _____
ROOM _____
LAUNDRY S__ F __ L __

LindenGrove

AD _____

DD _____

☐ Menomonee Falls ☐ Mukwonago ☐ New Berlin ☐ Waukesha

☐ Linden Court-Mukwonago ☐ Linden Court-New Berlin

☐ Linden Court-Waukesha ☐ Linden Heights ☐ Linden Ridge

Application for Admission

Date: _____

Name: _____ Sex: ☐ Female ☐ Male

Current Address: _____

City: _____ State: _____ Zip: _____

Telephone No.:_____

Birth Date: _____ Marital Status: ☐Married ☐Widowed ☐Divorced ☐Single/Never Married

Social Security Number: _____ Medicare Number: _____

Medicare Part D Provider: _____ Medicare Part D No.: _____

Health Insurance: _____ Health Ins. Policy No.: _____

Medicaid (Title 19) No.: _____ Long-Term Insurance:_____
Policy #:_____
Phone #:_____

Primary Care Physician: _____ Phone: _____

Will Physician follow patient's care at LindenGrove? ☐ Yes ☐ No

Religious Affiliation: _____

Please list, in order of preference, persons you wish to designate as contacts:

Federal law protects the privacy of health information and prevents LindenGrove from disclosing that health information to others, including family and close friends. The contact information you provided identifies individuals you authorize to receive notification of changes in condition and general health information status updates.

Please note that the contact information you provide on the second page is not considered confidential protected health information. Unless you instruct us otherwise in writing, LindenGrove may use this information to communicate with your contacts about LindenGrove's services, upcoming events at LindenGrove and fundraising opportunities. LindenGrove will not disclose this information to unrelated outside organizations.

EQUAL HOUSING OPPORTUNITY

Initial: _____

RESIDENT CONTACT LIST

1. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

2. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

3. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

4. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

5. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

6. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

7. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/alternate Phone Number
Authorized for Disclosure: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

8. _____ Name
_____ Address
_____ City/State/Zip
_____ Relationship
_____ Home Phone Number
_____ Work/Alternate Phone Number
Primary Contact For: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

Does someone have Durable Power of Attorney for Health Care? ☐ Yes ☐ No

If yes, please indicate: _____ _____ _____

Name & Relationship | Home Phone Number | Work Phone Number

Does the applicant have a Living Will? ☐ Yes ☐ No

If yes, please indicate: _____ _____ _____

Name & Relationship | Home Phone Number | Work Phone Number

Does someone have Durable Power of Attorney for Financial Matters? ☐ Yes ☐ No

If yes, please indicate: _____ _____ _____

Name & Relationship | Home Phone Number | Work Phone Number

Is there a Guardian appointed for the applicant? ☐ Yes ☐ No

FUNERAL HOME PREFERENCE: _____

Address: _____ Phone: _____

Prepaid Funeral Expenses:

Do you have a burial plot? ☐ Yes ☐ No _____

Do you have other prepaid funeral arrangements? ☐ Yes ☐ No _____

If yes, please described: _____

_____

_____

RESIDENT BILL OF RIGHTS:

____ I acknowledge receipt of the *Resident Bill of Rights*; I have been fully informed of those rights and was given the opportunity to ask questions relative to their nature and scope.

MAIL SERVICE AGREEMENT: LindenGrove's Policy is that every resident has the right to receive, send and mail sealed, unopened correspondence. No resident's incoming or outgoing correspondence may be opened, delayed, held or censored, except that a resident, guardian or physician may direct in writing that specific incoming correspondence be opened or held (HSS 132.31).

My choice is as follows:

____ To have all mail distributed to me (the resident) directly.

____ Personal mail will be delivered to me (the resident) directly (cards, letters, etc.); Business mail will be forwarded to the person listed below.

Name: _____ Relationship: ☐ Guardian ☐ Power of Attorney ☐ Other

____ I wish to have LindenGrove open all business mail I receive such as checks, medical bills, and statements, Medicare and Medicaid correspondence, provide the correct information requested such as insurance numbers, or obtain my signature to make a claim on my behalf.

If resident is discharged or expires, all mail will be returned to sender unless other arrangements are made.

Upon admission of resident, please provide LindenGrove with a copy of the following:

- ☐ Durable Power of Attorney for Health Care
- ☐ Durable Power of Attorney (Financial)
- ☐ Living Will
- ☐ Medicare Card
- ☐ Medicare Part D
- ☐ Health Insurance Card
- ☐ Social Security Card
- ☐ Medicaid (Title 19) Card
- ☐ Senior Care

Each undersigned represents and warrants that the information provided is true and correct. LindenGrove, Inc. is authorized to make all inquiries deemed necessary to verify the accuracy of the statements made herein and to determine individual or joint financial position.

Signed: _____ Date: _____
Applicant

Signed: _____ Date: _____
Legal Representative (if applicable)

Received By: _____ Date: _____
Authorized Representative of LindenGrove, Inc.

LindenGrove

Statement of Financial Condition of:

Name: _____ Date: _____

Monthly Income:

Social Security: ..... $ _____

Pension: ..... $ _____

Interest: ..... $ _____

Other Monthly Income (Indicate source):

Trust Fund _____ $ _____

Total Monthly Income: ($ _____)

Assets (Approximate Fair Market Value)

Savings & Checking Account(s) ..... $ _____

Stocks/Bonds ..... $ _____

Certificates of Deposits ..... $ _____

IRA ..... $ _____

Mutual Funds ..... $ _____

Real Estate (assessed value):

Primary Residence ..... $ _____

Other ..... $ _____

Other Assets (please describe)

Trust Fund _____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

Total Asset Value: ($ _____)

Do you have long term care insurance ☐ Yes ☐ No

Liabilities (Loans, Mortgages, Insurance Premiums, Pharmaceuticals, Medical Expenses, Credit Cards):

Type:	**Amount Owed**	**Payment Frequency**
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	