



STATUS _____ / _____
A.D. _____
MR# _____
ROOM _____
LAUNDRY S__ F__ L__

AD _____

DD _____

- Menomonee Falls Mukwonago New Berlin Waukesha
- Memory Care-Waukesha Memory Care-Mukwonago Memory Care-New Berlin
- Assisted Living - Mukwonago Assisted Living-Waukesha The Lodges

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.

Initial: _____



RESIDENT CONTACT LIST

1.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
2.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
3.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
4.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
5.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
6.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
7.	_____ Name	_____ Relationship	Authorized for Disclosure
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>
8.	_____ Name	_____ Relationship	Primary Contact For
	_____ Address	_____ Home Phone Number	Medical Issues <input type="checkbox"/>
	_____ City/State/Zip	_____ Work/Alternate Phone Number	Financial Issues <input type="checkbox"/>
			Other Issues <input type="checkbox"/>

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:

- | | |
|--|---|
| <input type="checkbox"/> Durable Power of Attorney for Health Care | <input type="checkbox"/> Health Insurance Card |
| <input type="checkbox"/> Durable Power of Attorney (Financial) | <input type="checkbox"/> Social Security Card |
| <input type="checkbox"/> Living Will | <input type="checkbox"/> Medicaid (Title 19) Card |
| <input type="checkbox"/> Medicare Card | <input type="checkbox"/> Senior Care |
| <input type="checkbox"/> Medicare Part D | |

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.



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
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____