



### Independent Living Application for Admission

Thank you for your interest in The House of the Good Shepherd, a non-sectarian, non-profit retirement community.

The House of the Good Shepherd does not discriminate in admission practices on the basis of age, ancestry, color, creed (religion), disability (including AIDS and HIV infection), veteran status, familial status, marital status, domestic partnership or civil union status, nationality, nation origin, race, sex, affectional or sexual orientation, gender identity or expression.

### General Information

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

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

Home Telephone # \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Name of Spouse (if applicable): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Prior Occupation: \_\_\_\_\_

Veteran:  Yes  No Spouse of a Veteran?  Yes  No

Religion: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Name of Person completing application if not self: \_\_\_\_\_



Relationship to Applicant: \_\_\_\_\_

Names of people living in your household:	Relationship:
_____	_____
_____	_____
_____	_____

**Health Insurance**

Medicare #: \_\_\_\_\_

Please check all parts in which you have coverage:

- Part A       Part B       Part C       Part D

If you are uncertain about your Medicare coverage, a staff member can help you.

Other Medical Insurance (e.g., Medigap, Long Term Care)     Yes     No

Type of Insurance	Company Name
_____	_____
_____	_____

**Physician**

Name of Primary Care Physician: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**Powers of Attorney and Advance Directives**

Who manages your financial affairs? \_\_\_\_\_

Does anyone have your Healthcare Power of Attorney?      Yes       No

If yes, name of Healthcare Power of Attorney: \_\_\_\_\_

Does anyone have your Financial Power of Attorney?      Yes       No

If yes, name of Financial Power of Attorney: \_\_\_\_\_

Do you have a legal guardian?      Yes       No

If yes, name of legal guardian: \_\_\_\_\_

Do you have an advance directive?      Yes       No

If yes, is the directive a:

- Living Will
- POLST (physician's orders for life-sustaining treatments)
- Durable Power of Attorney for Healthcare
- Medical Society of New Jersey DNR

***Please attach copies of all documents to this application.***

**Funeral Information**

In case of death, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of funeral home: \_\_\_\_\_ Phone: \_\_\_\_\_

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



Has the funeral been prepaid?      Yes       No

**Contact Information**

Please list the names and addresses of family members or others who may be contacted with information and/or in case of emergency. **NOTE: E-Mail Address is Mandatory.**

**Contact #1:**

First and Last Name: \_\_\_\_\_

Street Address & Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**Contact #2:**

First and Last Name: \_\_\_\_\_

Street Address & Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_



**Contact #3:**

First and Last Name: \_\_\_\_\_

Street Address & Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**Important Information:**

Gifts to anyone of money/financial support and/or gifts of property/valuables within the past five years will result in being ineligible for Medicaid for a period of time based on the value of the assets transferred. If you anticipate you may need Medicaid in the future, you should not transfer assets during your stay.

Medicare ONLY pays for short term rehabilitation and skilled nursing services after a three day hospital admission and stay. Observation days do not qualify. The need for assistance with basic activities of daily living (e.g., dressing, bathing) is not covered by Medicare.

**Certification of Application Information**

The Resident Applicant and his/her agents, confirm that, on this Application, HOTGS has been provided with a complete list of the applicant's current Financial Agents, all Powers of Attorney, Guardianship Commissions and/or other documents authorizing an agent to act for the Applicant or to have access to or to have control of any assets of the applicant (e.g., access to joint ownership of bank accounts, stocks, Social Security). Furthermore, the applicant and/or agents agree to inform HOTGS of any future appointments or revocations immediately.

The Applicant and his/her agents, in the event the applicant's funds are depleted and the applicant can no longer afford the cost of care, the applicant and his/her agents will apply for any and all state or federal assistance that may be available. The applicant further understands, and agrees, that the policy of The House of the Good Shepherd is not to extend charitable care



if a resident or patient transfers or dissipates assets other than to meet his/her reasonable and customary living expenses.

I hereby represent and certify that the information provided on this application is true and complete.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Resident Representative's Name: \_\_\_\_\_

Resident Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach the following to your application:

- Copies of the front and back of all your insurance cards
- Completed Prospective Resident Medical History
- Copy of long term care insurance policy, if applicable
- Copy of Powers of Attorney, if applicable
- Copy of Advance Directive, if applicable
- \$100 non-refundable application fee