THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

Skilled Nursing Short-Term, Post-Acute Application for Admission

Thank you for your interest in The House of the Good Shepherd, an Episcopal-sponsored, 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: _____

THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

Relationship to Applicant: _____

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 #: _____

Medicaid (for secondary)

Medicaid #:_____ ☐ ☐

THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

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: _____

THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

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. #: _____

THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail Address: _____

Relationship to Applicant: _____

Important Information:

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

Certification of Application Information

The 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: _____

THE HOUSE OF THE GOOD SHEPHERD
A Retirement Community

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

Rev. 12/19