Application for Admission to (Check all that apply)

____ Independent Living

____ Assisted Living

____ Skilled Nursing Short-Term, Post Hospital Rehabilitation

____ Skilled Nursing Long Term Care

____ Uncertain which level of services/care is appropriate

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

General Information

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.

We understand that completing the necessary admission paperwork can be daunting and have attempted to simplify this paperwork as much as possible.

In accordance with State of New Jersey Department of Health regulations, Medicaid/Medicaid Long Term Services and Supports (MLTSS) applicants may be placed on a Medicaid waiting list.

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:

____ _______________________________

____ _______________________________

____ _______________________________

To whom should the statement of expenses be mailed? Place an asterisk next to a name above or complete:

Name: ____

Home Address: ____

Health Insurance

Medicare #: ____

Please check the 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 (if applicable)

Medicaid #:__________________ Medicaid Application Filed? ☐ Yes ☐ No

Date Application Filed: _________________ Location Application Filed: _________________

Name of Medicaid Caseworker: ____

I am not already enrolled in Medicaid, but I believe I may be eligible: ☐ Yes ☐ No

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.

Burial 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: ____

Contact #4:

Contact Name: _________________________________ _______________________________
First Name 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 at less than fair market value 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 plan to be a resident of Independent Living, Assisted Living or Long Term Care and 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 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 Patient/Resident Applicant and his/her agents, confirm that, on this Universal 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

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