ADMISSION APPLICATION

Bartels Lutheran Retirement Community
1922 5th Avenue NW
Waverly, IA 50677
319-352-4540

Date _____ Applicant's Name _____

Social Security # _____ Date of Birth _____

How did you hear about our facility? _____

Present Address _____

Phone Number _____

Place of Birth _____

Married_____ Widow_____ Separated_____ Single_____ Divorced_____ # of Children _____

Spouse's Name _____ Is Spouse living_____ Deceased_____ SS# _____

Was applicant / spouse a veteran? Yes_____ No_____ WWI _____WWII_____VN_____K_____

VA file # (if applicable)_____ Branch of service _____

Previous Occupation _____

Church Affiliation: _____ Church Address: _____

Pastor's Name: _____

Living Preference

Nursing: Single room _____ Double room _____

Assisted Living: Studio_____ 1-bedroom _____ 2-bedroom _____

Eichhorn Haus Independent Living: 1-bedroom _____ 2-bedroom_____

Do you want the first available in any of the above living areas? _____

Contact Information

Name of Applicant's Sponsor for Admission _____

Relationship _____

Address _____

Home phone # _____ Business Phone # _____

Name of Alternate Contact Person _____

Relationship _____

Address _____

Home phone # _____ Business Phone # _____

What person or firm, if any, holds power of attorney for applicant?

Name _____ Telephone _____

Address _____

Name of conservator (if any) _____ Telephone _____

Address _____

If no Power of Attorney or Conservator, who handles applicant's affairs?

Name _____ Telephone _____

Address _____

Do you currently have Advanced Directives? Living Will _____ DNR _____

Hospital Preference_____ Address _____ Phone_____

Primary Physician _____ Address _____ Phone_____

Dentist_____ Address _____ Phone_____

Eye Doctor_____ Address _____ Phone_____

Pharmacy_____ Address _____ Phone_____

Funeral Home _____ Address _____ Phone_____

HEALTH INSURANCE INFORMATION: The facility requires copies of the Social Security card, Medicare card, Medicaid card, Health Insurance card.

Medicaid # _____ County _____ Caseworker _____

Medicare # _____ Medicare Part A: Yes _____ No _____
Medicare Part B: Yes _____ No _____

Supplement Insurance Company (If any) _____

Co. Address _____

Co. Phone _____ Policy # _____ Sponsoring Employer _____

Prescription Insurance Company (If any) _____Co. Address _____

Co. Phone _____ Policy # _____

Long Term Care Insurance Company (If any) _____ Co. Address _____

Co. Phone _____ Policy # _____

Is applicant able to pay privately? _____ If yes, total amount available? _____

APPLICANT'S CURRENT INCOME:

1) **Social Security** $_____

   If Direct Deposit, Bank Name, Branch Location, & Acct. # _____

2) **Pension** $_____ Name of Company _____

   Address of Company _____

   If Direct Deposit, Bank Name, Branch Location, & Acct. # _____

3) **Veteran's Pension** $ _____ Veteran's Name _____

If Direct Deposit, Bank Name, Branch Location, & Acct. # _____

4) **OTHER** Supplemental Security Income (SSI) $_____Dividends $_____

Business Income $_____ Interest Income $_____

Trust Fund $_____ Principal Amount $_____

Cash on Hand $_____

BANK ACCOUNTS:

Primary Bank Name & Address _____

Account # _____ Balance $_____

Names of Account Holders _____

APPLICANT'S PROPERTY: (Please indicate both individual and joint holdings)

Does Resident own home? Yes_____ No_____ Location _____

Estimated Value $_____ Unpaid Mortgage $_____

Co-Owners & Relationship, if any _____

Does Resident own other property? Yes_____ No_____ Value $_____

Type of Property (Residential, Commercial, Vacant Land) _____

Stocks &/or Bonds? Yes_____ No_____ Value $_____ Co. Name _____

Other Assets _____

Debts and Obligations _____

Has there been any disposition of assets within sixty (60) months prior to admission application?

Yes_____ No_____ If yes, Date _____ Amount $_____

Recipient's Name, Address, & Relationship ___

_____

HEALTH HISTORY AND CURRENT CONDITION:

Previous Nursing Home Stay? (Location & Dates) _____

Does Applicant have a Medical Power of Attorney or Advance Directive?_____

Does applicant have any history of mental retardation, mental illness or any other mental health problem?

Yes_____ No_____ If yes, please explain _____

In your own words, why is resident seeking placement in this facility? _____

_____

BARTELS LUTHERAN RETIREMENT COMMUNITY INCLUDES LICENSED NURSING CARE, CERTIFIED ASSISTED LIVING AND INDEPENDENT RETIREMENT HOUSING. IT IS DEDICATED TO SERVE ALL PERSONS REGARDLESS OF RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, DISABILITY OR ANY OTHER PROHIBITED BASIS OF DISCRIMINATION.

I hereby certify that I have carefully studied this application and understood it in detail and that I have answered correctly, to the best of my knowledge and belief, all the questions herein contained. Incomplete, fraudulent or untrue statements shall constitute sufficient reason to reject an applicant, dismiss a member already received and relieve the Home of any obligation under written contract with party concerned. Copies of prior years' tax documents may be requested for verification.

The Bartels Lutheran Retirement Community is a SMOKE FREE facility.

_____ _____

Signature of Applicant Signature of Sponsor

If returning application by mail, please send to:

Bartels Lutheran Retirement Community
1922 5th Ave. NW
Waverly, IA 50677