

Lutheran Healthcare Center



A Program of Lutheran Social Services

26 Harvard St., Worcester, Ma 01609
Phone: 508-754-8877 Fax: 508-745-7141
www.LHCare.org

APPLICATION FOR ADMISSION

Please Print

Name _____

Date _____

Address _____

City _____ State _____ Zip _____

Social Security # _____

Medicare # _____ Medicaid # _____

Telephone # _____ Email _____

Date of Birth (month, day, year) _____ Age _____

Other insurance _____

Birthplace _____ U.S. citizen: yes _____ no _____

LTC screening: yes ___ no ___

Religion _____ Marital Statue _____

Spouse's name _____

Father's name _____

Mother's maiden name _____

Work History

Occupation (work done during most of working life, even if retired)

Education level _____ Primary language _____

Military Service _____ Dates of Service _____

Applicant is now at home ____ or at --

Name of facility _____

Address _____

City _____ State _____ Zip _____

Primary contact person: _____

Telephone: _____

Physician: _____

Address: _____

City _____ State _____ Zip _____

Telephone _____

Medical diagnosis _____

Allergies _____

Mental status _____

Will physician attend here? Yes _____ No _____

MEDICAL REPORT FOR ADMISSION

Name _____ Age _____

Date _____

Address _____

City _____ State _____ Zip _____

Diagnosis, all systems _____

Present medications _____

Previous medical or surgical history

Pneumovax: Yes _____ No _____ Date _____

Tetanus diptheria vaccine: Yes _____ No _____ Date _____

Allergies _____

Is special diet required? Yes _____ No _____

If so, please give details _____

Chief complaints _____

PHYSICAL EXAMINATION

Please answer in detail

General condition _____

Ambulatory _____ Wheelchair _____ Bedridden _____

Height _____ Weight _____

Skin _____ Thyroid _____

Vision _____ Hearing _____

Teeth _____ Speech _____

Lungs _____ Blood _____

Urine _____ Abdomen _____

Genito-urinary:
Incontinence _____ Bowel _____ Bladder _____

Does applicant have any physical disabilities? Please state fully:

Does applicant have any mental impairment? Please describe in detail whether or not applicant is alert, forgetful, noisy, cooperative, and list any peculiarities in behavior. _____

Physician's signature & date: _____

FINANCIAL INFORMATION

Financial Manager:

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone: home _____ Work _____

Cell _____ Email _____

Is there a power of attorney? Yes ___ No ___ If yes, please provide copy.

Sources of Income:

| Type | Recipient's Name | Monthly Amount |
|-------------|-------------------------|-----------------------|
|-------------|-------------------------|-----------------------|

| | | |
|-----------------|-------|-------|
| Social security | _____ | _____ |
|-----------------|-------|-------|

| | | |
|--------------------|-------|-------|
| Retirement/pension | _____ | _____ |
|--------------------|-------|-------|

| | | |
|--------------|-------|-------|
| V.A. pension | _____ | _____ |
|--------------|-------|-------|

| | | |
|---------------|-------|-------|
| Rental income | _____ | _____ |
|---------------|-------|-------|

| | | |
|-----------------------------------|-------|-------|
| Income from annuities/investments | _____ | _____ |
|-----------------------------------|-------|-------|

| | | |
|----------------|-------|-------|
| Other(specify) | _____ | _____ |
|----------------|-------|-------|

Assets:

| Name of Bank | Type of Account | Value |
|---------------------|------------------------|--------------|
|---------------------|------------------------|--------------|

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you own:

Stocks _____ Bonds _____ CDs _____ Mutual funds _____

Approximate value _____

Insurance: Company (If more than one, please list separately on back):

Policy number _____ Face value _____

Have you created a trust or transferred assets in the last 60 months?

Yes___ No___

Explain _____

Please supply a copy of trust instrument

Do you own a home? Yes___ No___ Live alone? Yes___ No

Do you have long term care insurance? Yes___ No___

Company _____

Policy number _____

Address _____

City _____ State _____ Zip _____

Telephone _____

RESPONSIBLE PARTY (in planning and decision making for application care)

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone : Home _____ Work _____ Cell _____

Email _____

Is there a health care proxy? Yes ___ No ___ (If yes, Please provide copy)

EMERGENCY NOTIFICATION

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone : Home _____ Work _____ Cell _____

Email _____

BURIAL ARRANGEMENTS

Funeral home _____

Address _____

City _____ State _____ Zip _____

Telephone _____

**I hereby state that to the best of my knowledge and belief, the above stated information is true, correct and complete. All of the information will be kept confidential by Lutheran Healthcare Center of Worcester and will not be released without my written permission.

Signature of applicant & date _____

Signature of responsible party & date: _____