



# ARTMAN

*Leaders in Compassionate Care*

## APPLICATION FOR ADMISSION

- PERSONAL CARE
- SKILLED NURSING
- SHORT-TERM REHABILITATION
- RESPITE STAYS
- HOSPICE CARE

Please Return to the Admissions Office:

**MaryAnn McLaughlin**

*Director of Admissions*

Phone: **(215) 643-6333**, ext. **110**

Direct Dial: (215) 643-9894

Fax: (215) 643-5478

E-mail: [mmclaughlin@artmanhome.com](mailto:mmclaughlin@artmanhome.com)

Artman Lutheran Home

250 North Bethlehem Pike

Ambler, PA 19002





### **Entrance Procedure**

If you are prepared to take residency sometime within the next 30 days:

- a. Contact the Admissions Office to discuss eligibility criteria.
- b. Complete and submit forms 1 and 2 of the Application for Admission and return to the attention of the Admissions Office with your check made payable to Artman Lutheran Home in the amount of \$200. If you are applying with a spouse, two applications must be completed and the processing fee is \$300. A \$100 processing fee is required for Respite Stays. There is no processing fee for Short Term Rehabilitation Stays.
- c. Your personal physician must complete and forward the medical evaluation form for Personal Care residents to the Admissions Office. Medical evaluation forms are available in the Admissions Office.
- d. You will be contacted to set-up an evaluation meeting with the Admission Committee.
- e. Confirm admission date and move-in arrangements with the Admissions Office.

### **Future Occupancy and Procedure for Wait List Status**

Artman Lutheran Home's waiting list is growing substantially because of the limited openings each year. Although openings can sometimes develop sooner than expected for a number of reasons, it is recommended that you apply in advance.

- a. Contact the Admissions Office to discuss eligibility criteria.
- b. Complete and submit forms 1 and 2 of the Application for Admission and return to the attention of the Admissions Office with your check made payable to Artman Lutheran Home in the amount of \$200 or \$300 for a couple. A fee of \$100 is required for Respite Stays.
- c. Your personal physician must complete and forward the medical evaluation form for Personal Care residents to the Admissions Office.
- d. A Wait List number will be assigned prior to admission with notation of the desired move-in time frame.
- e. Wait List Applicants will be notified in the order of reservation number when a unit is expected to become available.
- f. Applicants will have 48 hours to accept a unit. If the wait period has been more than 60 days, an updated medical evaluation will be required.
- g. If you are not ready to proceed with the Entrance Procedure, then the next Wait List applicant will be notified. You may decline three available units before being moved to the end of the Wait List.

**ARTMAN ADMISSION APPLICATION: PERSONAL INFORMATION**      **FORM 1**

**Please Print**

Applicant's Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ Alternate Telephone Number (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_

Medicare Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Account/Policy Number \_\_\_\_\_

Other Insurance Provider \_\_\_\_\_

Account/Policy Number \_\_\_\_\_

Prescription Plan     Yes     No

Name \_\_\_\_\_

Account/Policy Number \_\_\_\_\_

Access Number \_\_\_\_\_

PACE Number \_\_\_\_\_

**Current Living Status**

Home       With no home health services       With home health services

Hospital Name \_\_\_\_\_

Nursing or Personal Care Home Name \_\_\_\_\_

Other \_\_\_\_\_

Approximate date you wish to enter Artman \_\_\_\_\_

How did you hear about Artman?     Self       Friends       Church       Family  
    Artman Staff     Social Service     Physician     Advertisement  
    Other

**Personal Information**

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

US Citizen?  Yes  No

Caucasian  African American  Hispanic  Native American  Asian  Other

Married  Single  Widow/er  Divorced

Lifetime Occupation \_\_\_\_\_

Veteran  Yes  No Veterans Benefits  Yes  No

Highest Level of Education  No Schooling  8th Grade/Less  9-11 Grades  High School  
 Technical/Trade School  Some College  Bachelor's Degree  Graduate Degree

Known Allergies \_\_\_\_\_

Father's Full Name \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_

Spouse's Full Name  Living  Deceased \_\_\_\_\_

**Physician Information**

Name of Primary Physician \_\_\_\_\_

Name of Practice \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Telephone Number (\_\_\_\_) \_\_\_\_\_

**Religious Information (Optional)**

Religion \_\_\_\_\_

Involvement  Active  Attendance Only  Inactive  None

Name of Church/Synagogue \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Name of Pastor/Priest/Rabbi \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Billing Information**      Power of Attorney  Yes     No

Name of Person to Receive/Pay Monthly Statements \_\_\_\_\_

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

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Number (\_\_\_\_) \_\_\_\_\_ Work Telephone Number (\_\_\_\_) \_\_\_\_\_

Cell Phone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Primary Contact**      Power of Attorney  Yes     No

Name of Person to Contact in Emergency \_\_\_\_\_

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

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Number (\_\_\_\_) \_\_\_\_\_ Work Telephone Number (\_\_\_\_) \_\_\_\_\_

Cell Phone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Second Contact**      Power of Attorney  Yes     NO

Name of Person When Primary Contact Is Unavailable \_\_\_\_\_

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

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Number (\_\_\_\_) \_\_\_\_\_ Work Telephone Number (\_\_\_\_) \_\_\_\_\_

Cell Phone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Third Contact**      Power of Attorney  Yes     No

Name of Person When Primary Contact Is Unavailable \_\_\_\_\_

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

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Number (\_\_\_\_) \_\_\_\_\_ Work Telephone Number (\_\_\_\_) \_\_\_\_\_

Cell Phone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Funeral Arrangements**

Name of Funeral Director \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Funeral Home Telephone Number (\_\_\_\_) \_\_\_\_\_

Name of Person Responsible for Funeral Arrangements \_\_\_\_\_

Applicant's Relationship to this person \_\_\_\_\_

Home Telephone Number (\_\_\_\_) \_\_\_\_\_ Work Telephone Number (\_\_\_\_) \_\_\_\_\_

Cell Phone Number (\_\_\_\_) \_\_\_\_\_

Do you have an Advanced Directive/Living Will?  Yes  No

Would you like additional information on Advanced Directives?  Yes  No

**Please submit a copy of Power of Attorney and Advanced Directive/Living Will if these documents exist**

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

Signature of Person Completing This Form \_\_\_\_\_

Print Name \_\_\_\_\_

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

Date \_\_\_\_\_

***Copies of all current statements must be attached.***

**Income**

Type	Amount Per Month	Total Amount Annually
Social Security	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Annuity/Trust	\$ _____	\$ _____
Rental	\$ _____	\$ _____
Dividends	\$ _____	\$ _____
Interest	\$ _____	\$ _____
Bonds	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
<b>Total Income</b>	<b>\$ _____</b>	<b>\$ _____</b>

**Banking**

Checking Accounts: <i>Bank(s)</i>	Current Balance
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
Savings Account, CDs, Money Market, Banks, Other	
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____

**Stocks/Bonds**

Stocks: <i>Company</i>	Number of Shares	Current Value
1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____
Bonds	Type	Current Value
1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____

**Real Estate (Please note any jointly held property)**

Real estate: <i>(In Applicant's Name)</i> Type and Location <i>(List Address)</i>	Value	Mortgage Amount
1. _____	\$ _____	\$ _____
2. _____	\$ _____	\$ _____
3. _____	\$ _____	\$ _____

Are you planning to sell any/all of your real estate?     Yes     No

**Life Insurance Policies (On Applicant's Life or owned by the Applicant)**

Company	Policy Number	Face Value	Beneficiary
1. _____	_____	\$ _____	_____
2. _____	_____	\$ _____	_____
3. _____	_____	\$ _____	_____

Describe any debts, mortgages, obligations, etc., affecting income or assets: \_\_\_\_\_

Upon entering Artman's Skilled Nursing Care Unit, are you willing to file for financial assistance should the need arise?     Yes     No

In the past five years, have you given any gifts exceeding \$5,000?     Yes     No  
 If so, in what amount and to whom?

\_\_\_\_\_





*I affirm that the foregoing is a true statement of the facts known to me and is submitted as part of an application for residence in the facility. I understand that a lack of truth in my statements in this application is grounds for either a denial of admission or, if permitted by law, a discharge after admission. Further, if admitted, I affirm that, while I am in residence at the facility, (a) I will use the funds and resources I have identified above, as well as all income received from these funds and resources and any other income which I may receive while I remain in residence at the facility, primarily for payment to the facility for services provided to me; and, (b) I will submit an Annual Statement of my financial status to the facility. Finally, I hereby also authorize any and all financial institutions or entities with whom I have a business, commercial or fiduciary relationship to release any and all requested financial information to the facility as long as I remain in residence at the facility.*

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Completing This Form \_\_\_\_\_ Date \_\_\_\_\_

*The Civil Right Act of 1964 prohibits discrimination. The word "discrimination" shall be understood to mean "discrimination on the basis of race, color, national origin, ancestry, religious creed, sex, age or handicap," as used in Title VI of the Civil Rights Act of 1964, the Pennsylvania Human Relations Act of 1955, as amended, Section 504.*

## Quick Reminder List

### Pre-admission Requirements

- An attending physician will be designated prior to admission. Residents may utilize one of our House Physicians or retain their private attending physician as long as he/she abides by state, federal, and Artman credentialing requirements. Please confirm this with the Admissions Office at (215) 643-9894. If the resident will be utilizing an Artman physician, arrangements must be made to have copies of medical records transferred to the new attending physician.
- According to state regulations, name and telephone of Funeral Home must be provided.
- Any clothing you wish to be laundered by Artman must be washable (not dry cleaned). Clothing must be labeled with resident's name.
- You will need to contact the telephone and cable companies directly if you wish to use these services.
  - Verizon: (800) 837-4966
  - Basic cable is provided. For additional upgraded services, call Comcast "Bulk Services" at (800) 391-3000.
- Confirm move-in date with the Admissions Office.

### Necessary Items for Day of Admission

*Please make items 1-7 available to us for photocopying prior to or upon admission.*

1. Social Security Card
2. Medicare Card
3. Insurance/Hospitalization Card (Blue Cross, AARP, etc.)
4. PACE Card (if applicable)
5. Pharmaceutical Insurance Card (if applicable)
6. Power of Attorney or Legal Guardianship Documents
7. Advanced Directive/Living Will (if applicable)
8. \$200 Application Processing Fee (if not already submitted)

Note: Valuable items and cash should NOT be kept in the resident's room. Residents are encouraged to open a trust fund account. Valuable items should be kept in the safe. Admissions personnel will explain the procedure.

Please call **MaryAnn McLaughlin** in the Admissions Office at **(215) 643-9894** if you have any questions.

