Congregational Home

13900 W. Burleigh Road Brookfield, WI 53005 Ph: 262-781-0550 Fx: 262-781-0559

Application for Admission

Updated 6-1-19

*The following Application is required to help determine Needs, Services Requested and Admission Eligibility. In addition, some of the questions are for Admission **Pre**-Registration, i.e. religion & occupation. If you prefer, you may choose to answer these questions at the time of Admission Registration rather than Pre-Registration. **The Financial Statement is also required to determine Eligibility.***
Please note that Congregational Home Prohibits the use of all Vaping & Tobacco Products (smokeless & smoking) throughout our Indoor Facilities & Outdoor Grounds, for all Employees, Residents, Family Members and Visitors.

Applicant Name_____
First Name Middle Name Last Name

Preferred Name (what you want Congregational staff to call you by)_____

Gender: Male / Female **Age**_____**D.O.B.**_____**Social Security#**_____

Marital Status: Never Married / Married / Divorced / Legally Separated / Widowed

US Citizen? NO / YES **Primary Language** (language used to communicate with others)_____

Religion_____Are you a Member of The **First Congregational Church of Wauwatosa**? NO / YES

Occupation_____

Home Address_____
Street City State Zip Code

Phone: Home_____Cell_____

Home Address is: □ House/Condo □ Independent Apartment □ Assisted Living □ Nursing Home □ Other

Applicant lives with: □ Alone □ Spouse □ Adult Child □ Sibling □ Significant Other □ Other_____

Applicant is currently at (example: Home, Elmbrook Hospital, etc):_____

Requested Level of Care:

____Independent Living ____Assisted Living

____Long-Term Nursing Home ____Short-Term Rehab

Special Services Requested: □ Hospice □ Memory Care

Has the Applicant had a previous stay at Congregational Home? NO / YES, when_____

Has the Applicant had a previous stay in another Facility:

Rehab Facility? NO / YES, where/when_____

Nursing Home Facility? NO / YES, where/when_____

Assisted Living Facility? NO / YES, where/when_____

Are you working with an AGENCY that Provides Advice, Consultation, Case Management or Placement Assistance, such as *A Place For Mom*; *Senior Planning & Advisors; Stowell Associates;* Etc…?

NO / YES - if YES, please name Agency:_____

INSURANCE

Do you have MEDICAID? NO / YES **Congregational Home does not accept Medicaid as a form of payment**

Do you have MEDICARE? NO / YES

Applicant has ____Traditional Medicare #_____**What Parts?** □ **Part A** □ **Part B**

____Medicare Advantage / Replacement Plan #_____
List Company Name, i.e. AARP, United HealthCare, Humana, Anthem Blue Cross, etc…
and Claims Address & Phone Number:

_____

_____

Do you have LONG-TERM CARE INSURANE? NO / YES

Name of Company:_____

Do you have OTHER INSURANCES? NO / YES, List Company Name, Policy / ID #, Claims Address, Phone Number

□ Secondary / Supplemental Plan_____

_____

□ Primary Commercial / Employer Plan (full-time employment)_____

_____

□ Prescription Drug Plan_____

_____

□ Other Plan_____

PHYSICIANS

Nursing Home & Assisted Living residents are required to have an Attending Primary Care Physician (PCP) to follow care at the facility, sign facility orders & take facility staff calls 24 hours a day. If a Community PCP is willing to do this, most will require residents to go to their clinics to be seen.

We can assign a Congregational PCP to you, who will see you here, not at an outside clinic.
Would you like us to assign a Congregational PCP to you? YES / NO, if No, please list your PCP below

Primary Care Physician Name, Address, Phone#_____

_____

_____**Date Last Seen**_____

Dentist Name, Address, Phone#_____

_____

_____**Date Last Seen**_____

Ophthalmologist/Optometrist Name, Address, Phone#_____

_____

_____**Date Last Seen**_____

Other Physicians Name, Address, Phone#_____

_____

_____**Date Last Seen**_____

ADVANCE DIRECTIVES

Does Applicant have a Living Will? NO / YES

Does Applicant have a Power Of Attorney for HEALTHCARE? NO / YES, list info below:

Name_____

Relationship_____ Email Address_____

Full Address_____

Phone: Home_____ Mobile_____ Work/Other_____

Is Power of Attorney for Healthcare ACTIVATED? NO / YES
(Activated means 2 Physicians have signed a form stating Applicant is Mentally Incapacitated & can't make their own medical decisions)

Does Applicant have a Power Of Attorney for FINANCES? NO / YES, list info below:

Name_____

Relationship_____ Email Address_____

FULL Address_____

Phone: Home_____ Mobile_____ Work/Other_____

Does Applicant have a Legal Guardian of PERSON (HEALTHCARE)? NO / YES, list info below:

Name_____

Relationship_____ Email Address_____

FULL Address_____

Phone: Home_____ Mobile_____ Work/Other_____

Does Applicant have a Legal Guardian of ESTATE (FINANCES)? NO / YES, list info below:

Name_____

Relationship_____ Email Address_____

FULL Address_____

Phone: Home_____ Mobile_____ Work/Other_____

Does Applicant have a Court Order or Court Date for Protective Placement? NO / YES

Prior to Admission, please provide copies of Social Security Card, Medicare Card, Other Insurance Cards and all Power of Attorney, Activation, Living Will, Guardianship & Protective Placement Documents.

CONTACTS

BILLING CONTACT: (Where Congregational Bills Will Be Sent To)

____Applicant ____Healthcare POA ____Financial POA ____Guardian of Person ____Guardian of Estate ____**OTHER:**

OTHER Name_____

Relationship_____Email Address_____

FULL Address_____

Phone: Home_____Mobile_____Work/Other_____

EMERGENCY CONTACTS: (For Medical Emergency or Death. If #1 Contact is not available, we will call #2 Contact & so on)

#1 Contact (If Healthcare POA is ACTIVATED OR if there is a Guardian of Person, this person must be #1 Contact)

____Healthcare POA ____Financial POA ____Guardian of Person ____Guardian of Estate ____**OTHER:**

OTHER Name_____

Relationship_____Email Address_____

FULL Address_____

Phone: Home_____Mobile_____Work/Other_____

#2 Contact

____Healthcare POA ____Financial POA ____Guardian of Person ____Guardian of Estate ____**OTHER:**

OTHER Name_____

Relationship_____Email Address_____

FULL Address_____

Phone: Home_____Mobile_____Work/Other_____

#3 Contact

____Healthcare POA ____Financial POA ____Guardian of Person ____Guardian of Estate ____**OTHER:**

OTHER Name_____

Relationship_____Email Address_____

FULL Address_____

Phone: Home_____Mobile_____Work/Other_____

Funeral Home: In the event of death, we need a listed Funeral Home on file. **If no Funeral Home is listed, we will assign Becker Ritter Funeral Home in Brookfield.** Please list Funeral Home Name, Address, Phone#_____

_____

SIGNATURE_____**DATE**_____

Applicant / Responsible Party

Relationship if not signed by Applicant_____

Prior to Admission, please provide copies of Social Security Card, Medicare Card, Other Insurance Cards and all Power of Attorney, Activation, Living Will, Guardianship & Protective Placement Documents.