The Legacy at St. Joseph's

Hands to Serve, Hearts to Love

CONFIDENTIAL APPLICATION FOR RESIDENCY

Please complete and return this application with all supporting documentation to:

* 9244 29th Avenue – Kenosha, WI 53143

OR

* Email to: asi@legacy-sj.org

Please contact Asi Schmid-Dondero, Administrator with any questions at 414-807-8601

GENERAL INFORMATION – Please print

Date of Application: _____

Name:_____ Social Security #_____
First Middle Last

Address: _____ City:_____ State:_____ Zip:_____

Telephone: (H) _____ (C)_____ Email:_____

Birthdate:_____/_____/_____ Current / Former Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

CURRENT LIVING SITUATION

Where do you currently live ?

☐ Senior Complex ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Group Home

☐ Apartment ☐ House or Condo (If yes, do you own or rent?) ☐ Own ☐ Rent

Do you currently live alone ?

☐ No: Who lives with you ?_____

☐ Yes: Do you use any support services (e.g. home health care, transportation, delivered meals)?
Please indicate services you use, if applicable:_____

How did you hear about The Legacy at St. Joseph's?_____

EMERGENCY CONTACTS

Name #!:_____ Email: :_____

City and State: _____ Relationship: _____ Phone: _____

Name #2:_____Email: :_____

City and State: _____ Relationship: _____ Phone: _____

MEDICAL AND RESIDENTIAL INFORMATION

Primary Care Physician's Name_____ Phone: (____)_____

What medical or health conditions do you have?_____

_____

What medications do you take? (or attach list) _____

_____

_____

Do you require others to assist you with your medications by:

Reminding you to take medications?	□ Yes	□ No
Setting up your medications for you?	□ Yes	□ No
Helping administer your medications?	□ Yes	□ No

Do you require a special diet or assistance with eating? □ Yes □ No (if yes please describe):

_____

Do you smoke? ☐ Yes ☐ No Note: The Legacy at St. Joseph's is a non-smoking facility and property.

Have you previously been admitted to a residential facility? ☐ Skilled Nursing (Nursing Home)

☐ Mental Health / Psychiatric ☐ Rehabilitation ☐ Developmentally Disabled ☐ Other

Name of facility:_____

Dates of stay:_____ Reason:_____

Have you had a hospital stay within the past 6 months? ☐ Yes ☐ No

Name of facility:_____

Dates of stay:_____ Reason:_____

DAILY LIVING

How do you enjoy spending your time? What hobbies do you have?_____

_____

Please describe yourself in the following areas in whether you need none, some or full assistance:

	None	Some	Full		None	Some	Full
Bathing…….	☐	☐	☐	Shopping…….	☐	☐	☐
Eating…….	☐	☐	☐	Laundry…….	☐	☐	☐
Dressing…….	☐	☐	☐	Toileting…….	☐	☐	☐
Housekeeping…….	☐	☐	☐	Walking…….	☐	☐	☐
Finances…….	☐	☐	☐	Transportation…..	☐	☐	☐

What other assistance do you feel you need?_____

What special equipment do you require?_____

LEGAL RESPONSIBILITY (Please check all that apply)

☐ Power of Attorney for Health Care

Activated: ☐ Yes ☐ No If yes, date activated:_____

_____ _____

Responsible Agent (Primary) **Responsible Agent (Alternate)**

☐ Power of Attorney for Finances (Durable)

_____ _____

Responsible Agent (Primary) **Responsible Agent (Alternate)**

☐ Court Appointed Guardian

_____

Name of Guardian

Copies of applicable documents must be presented at time of admission

FINANCIAL INFORMATION

The Legacy at St. Joseph's has a monthly room rate between $4,500.00 and $7560.00 plus the cost of personal care service points and fees. Applicants are responsible for providing financial information demonstrating that they have sufficient financial resources to allow residency for one-year minimum. We do accept long-term care insurance.

Please complete the attached Confidential Financial Statement and submit with this application.

I understand and agree that this application is neither a contract nor a reservation for residence at The Legacy at St. Joseph's. Nothing contained in this document obligates or entitles me to a room, until an Admission Agreement has been signed by all parties involved. I certify that all of the information that I have given on this application is correct and complete and hereby authorize The Legacy at St. Joseph's to make any inquiries necessary to evaluate my eligibility to reside at The Legacy at St. Joseph's.

Signature of Applicant:_____ Date:_____

Is there someone who helped you fill out this application? If so, may we contact them? □ Yes □ No

Name:_____ Relationship:_____

Address_____ Email:_____

Phone: Home_____ Cell_____ Work_____

CONFIDENTIAL FINANCIAL STATEMENT

For purposes of applying for admission to The Legacy at St. Joseph's, I am providing the following complete and accurate description of my financial condition.

Name:_____ Date of Birth:_____

Address:_____

Marital Status:_____ If married, name of spouse:_____

INCOME: Please identify your monthly income. If you are married, include the income of your spouse in the appropriate column. If you receive a type of income that is not listed, use the "other" category to identify this income. Unless expressly noted, you represent that all income is available to pay for your care and/or services. If a source of income is not applicable, mark N/A in the box. Please use additional pages as necessary.

Monthly Income	***Applicant (per month)***	***Spouse (per month)***
Social Security	$	$
Veteran's Benefits	$	$
SSI (Supplemental Security Income)	$	$
Pension	$	$
Retirement Plans	$	$
Disability Plans	$	$
Alimony	$	$
Income from Stocks and Bonds	$	$
Rental Income Paid to You	$	$
Annuities	$	$
Trust Fund	$	$
Interest Income from Savings	$	$
Other:	$	$
Total Monthly Income	$	$

ASSETS: **Please list your current assets and provide proof of all assets**.

If an asset is owned by a trust, indicate the name and type of trust in the owner column and The Legacy will need a copy of that trust. If an asset is jointly owned, identify the other owners and your percentage of ownership. Unless expressly noted, you represent that the listed assets are available to pay for your care and/or services. All boxes should be completed. If an asset types is not applicable, mark N/A in the owner and amount box. Please use additional pages as necessary.

Assets	**Owner** (applicant, spouse, jointly, trust). If jointly, identify co-owner. If trust, identity name of trust.	**Amount** ***Must specify if Not Applicable***
Checking Account Name of Bank:_____ Interest Bearing: □ Yes □ No		$
Additional Checking Account Name of Bank:_____ Interest Bearing: □ Yes □ No		$
Savings Account Name of Bank:_____		$
Additional Savings Account Name of Bank:_____		$
Cash on Hand		$
Stocks Description:_____		$
Bonds Description:_____		$
Certificates of Deposit		$
Money Owed to You		$
Real Estate Owned Description:_____		$
Land Contract		$
Vehicles		$
Burial Trust		$
Other:_____		$

TRANSFER OF ASSETS: Please identify any assets or other financial resources worth over $5,000 that you have given away or sold for less than fair market value within the last five years. Please use additional pages as necessary.

Description of What was Sold or Given Away:_____
By Whom:_____
To Whom:_____
Date of Gift or Sale:_____
Total Market Value:_____
Amount Received:_____

Please sign if Not Applicable and there were NO Transfer of Assets:_____

LIABILITIES: Indicate any significant liabilities that you owe. All boxes should be completed. If a liability is not applicable, mark N/A in the amount box. If a liability type is not listed, please use the "other" category to identify those liabilities. Please use additional pages as necessary.

Liabilities	**Amount** ***Must specify if Not Applicable (N/A)***
Credit Cards	$
Taxes	$
Medical Bills	$
Mortgage	$
Loans: Describe:_____	$
Health Insurance Costs:	$
Other: Describe:_____	$

POWER OF ATTORNEY FOR FINANCES:

Do you have a Power of Attorney for Finances: ☐ Yes ☐ No
If yes, please provide name of agent:_____

MEDICARE:

Are you enrolled in Medicare Part A? ☐ Yes ☐ No

Are you enrolled in a Medicare Advantage Plan? ☐ Yes ☐ No

If you are not eligible, do you have an equivalent insurance policy? ☐ Yes ☐ No

Do you have a supplemental Medicare policy (Medigap)? ☐ Yes ☐ No
If yes, please list insurance provider_____

LONG TERM CARE INSURANCE:

Do you have long term care insurance? ☐ Yes ☐ No If yes, provide name of insurance company:_____

LIFE INSURANCE:

Do you have life insurance? ☐ Yes ☐ No If yes, provide the following:

Cash Value:_____

Face Value:_____

Company Name:_____

Date Issued:_____

ACKNOWLEDGEMENT:

By signing this form, I represent and warrant that the above information is true and correct and accurately reflects my financial condition and the resources that are available to pay for my care and/or services. I understand that The Legacy at St. Joseph's will be relying on the information provided herein and may terminate any and all agreements with me if I provide false or misleading information. I further give The Legacy at St. Joseph's permission to verify the information provided herein. I also understand that I may be required to provide supporting documentation regarding the financial data I have provided and provide updated financial information and agree to do so upon request. I certify that I have adequate resources to meet my financial responsibilities if I am accepted into this facility. I also agree to inform the facility immediately of any changes in my financial condition.

_____ _____

Signature of Prospective Resident **Date**

If prospective resident is unable to sign, complete the following:

Name of Resident Representative: _____

Authority to Act:_____

Address:_____

Telephone: Home_____Cell_____ Work_____

_____ _____

Signature of Resident Representative **Date**

Please contact Asi Schmid-Dondero, Administrator at 414-807-8601 with any questions