

JENKINS SENIOR LIVING COMMUNITY

St. Elizabeth Rehabilitation and Nursing Center 3320 Benson Ave. Baltimore, MD 21227 410-644-7100

St. Ann Adult Day Care 3308 Benson Ave. Baltimore, MD 21227 410-646-6533

Caritas House Assisted Living 3308 Benson Ave. Baltimore, MD 21227 410-646-6600

APPLICATION FOR ADMISSION

DATE: _____

APPLICANTS NAME: _____ TELEPHONE NO: _____

STREET ADDRESS: _____ GENDER: MALE FEMALE

CITY: _____ STATE: _____ ZIP: _____ SSN#: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ CITIZENSHIP: _____

PLACE OF RESIDENCE (if different from above): _____

HOW LONG AT CURRENT RESIDENCE? _____ YRS. _____ MOS. EDUCATION: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED SEPARATED DIVORCED

RELIGION: _____ PARISH: _____ PASTOR: _____

FORMER OCCUPATION: _____ MILITARY SVC. DATES: _____ BRANCH: _____

FATHER'S NAME: _____ BIRTHPLACE: _____

MOTHER'S MAIDEN NAME: _____ BIRTHPLACE: _____

SPOUSE OF APPLICANT: _____ OCCUPATION/DATE OF DEATH: _____

CHILDREN OF APPLICANT

ADDRESS & ZIP CODE

PHONE NUMBERS

(please use reverse side if more space is needed)

BROTHERS/SISTERS OF APPLICANT

ADDRESS & ZIP CODE

PHONE NUMBERS

NAME, ADDRESS, ZIP CODE, TELEPHONE NUMBERS OF PERSONS TO NOTIFY IN CASE OF MEDICAL EMERGENCY OR DEATH (PLEASE LIST TWO NAMES):

- 1. _____
- 2. _____

FINANCIAL STATEMENT

(Use additional sheet if necessary)

LIST OF MONTHLY SOURCES OF INCOME:

Social Security _____	\$ _____
Supplemental Security Income _____	\$ _____
Pensions (give source) _____	\$ _____
Interest on Savings Accounts _____	\$ _____
Ground Rents _____	\$ _____
Annuities _____	\$ _____
Trust Funds (describe type) _____	\$ _____
Dividends _____	\$ _____
Other Income (state type) _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____

LIST ALL REAL ESTATE, LOCATION, ASSESSED VALUE AND ENCUMBRANCES:

LOCATION	NAMES ON DEED	VALUATION	EMCUMBRANCES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RETIREMENT ACCOUNTS:

TYPE _____	VALUE _____
TYPE _____	VALUE _____

STOCKS AND BONDS (List by name, all co-owners, number of shares, and current value)

NAME	OWNERS	NO. OF SHARES	TOTAL CURRENT VALUE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CASH IN FINANCIAL INSTITUTIONS (List bank name and all co-owners, account no. and amount):

BANK & ADDRESS	NAME(S) ON ACCOUNT	ACCOUNT NO.	AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FINANCIAL STATEMENT

(Use additional sheet if necessary)

LIFE INSURANCE

POLICY NO. COMPANY PAID-UP PREMIUM FACE VALUE LOAN AMOUNTS CASH VALUE BENEFICIARY

LONGTERM CARE INSURANCE _____

SUPPLEMENTAL MEDICAL INSURANCE _____

PHARMACY COVERAGE/COMPANY _____

MED PART D PLAN & ID # _____

MEDICARE NUMBER: PART A: _____ PART B: _____

PERSON RESPONSIBLE FOR MEDICAL ASSISTANCE APPLICATION AND/OR RECERTIFICATION:

MEDICAL ASSISTANCE NUMBER: _____ EFFECTIVE DATE: _____

MEDICAID WAIVER YES ___ NO ___ MEDICAID WAIVER WAITING LIST YES ___ NO ___

OTHER PERSONAL PROPERTY (ARTICLES OF VALUE) _____

HAVE YOU WITHIN THE LAST FIVE YEARS DISPOSED OF ANY PROPERTY, CASH OR OTHER ASSETS AND IF SO, HOW?

UNPAID DEBTS OR CLAIMS: TO WHOM AND AMOUNT: _____

IS ANYONE HOLDING ANY CASH OR OTHER KINDS OF ASSETS FOR YOU? (List name, address, telephone no. and amount)

NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON HAVING POWER OF ATTORNEY:

NAME, ADDRESS AND TELEPHONE NUMBER OF ATTORNEY:

DO YOU HAVE A WILL? _____ LOCATION _____

NAME, ADDRESS AND TELEPHONE NO. OF EXECUTOR: _____

PLEASE INDICATE YES OR NO IN EACH BLANK:

____LIVING WILL ____ADVANCED DIRECTIVES ____POWER OF ATTORNEY FOR MEDICAL DECISIONS

____PALLIATIVE CARE/DO NOT RESUSCITATE

NAME, ADDRESS AND TELEPHONE NO. OF PERSON HAVING DEED TO BURIAL OR CEMETERY LOT:

LOCATION OF CEMETARY PLOT/S, FUNERAL HOME

NAME, ADDRESS AND TELEPHONE NO. OF PERSON WHO WILL MAKE ARRANGEMENTS FOR BURIAL:

NAME, ADDRESS AND TELEPHONE NUMBER OF PERSONAL PHYSICIAN: _____

NAME, ADDRESS & TELEPHONE NUMBER OF PERSONAL DENTIST: _____

YOUR REASONS FOR SEEKING ADMISSION: _____

By signing this application, you are granting permission to share this information with the programs in the Jenkins Senior Living Community to facilitate your care.

SIGNATURE OF APPLICANT

DATE

SIGNATURE OF PERSON COMPLETING
(if different from applicant)

DATE

SIGNATURE OF POWER OF ATTORNEY
(FINANCIAL)

DATE

SIGNATURE OF POWER OF ATTORNEY
(HEALTH CARE)

DATE

REVIEWED AND APPROVED BY BUSINESS OFFICE MANAGER

SIGNED

DATE

Jenkins Senior Living Community programs are licensed by the State of Maryland and are operated by Associated Catholic Charities. Discrimination is prohibited based on race, color, sex, creed, age, religion, handicap, or national origin. This non-discriminatory policy also applies to employment practice.