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.