INFORMATION REQUEST LIST FOR ADMISSION CONSIDERATION

The following items are needed to complete your application and begin the review process. All items, when applicable, must be received prior to consideration for the waiting list. Please contact the Admissions Office at (202) 966-6667 extension 3302 if you have any questions.

___________ **Completed and Signed Application**

___________ **Copy of Social Security Card**

___________ **Copy of Medicare Card**

___________ **Copy of Medicare Part D card (front and back)**

___________ **Copy of Medicaid Card or Copy of the Application with Case Worker's Name and Contact Number**

___________ **Picture ID (Proof of Citizenship)**

___________ **If additional insurance applies, include a copy of the card and benefit information**

___________ **Copy of all Advanced Directives including Living Will, Health Care Power of Attorney and Financial Power of Attorney and Organ Donation Plans/Arrangements**

Medical Assistance Application Documents:

___________ **Copy of all Life Insurance Policies**

___________ **Copy of Current Year Social Security Award Letter**

___________ **Copy of Current Year Pension, Annuity, and/or Retirement Verification**

___________ **Current Monthly Statements for all Accounts including: Checking, Savings, Money Market, Stocks, Bonds, Certificates of Deposit etc.**

___________ **Copy of Tax Returns**

Medical and Dental Records for at least the prior two years including:

___________ **Psychosocial Summary/Social History completed by a Social Worker**

___________ **Diagnoses, Medications, Treatment Plans**

___________ **Current Chest X-ray (completed within prior 6 months)**

___________ **Negative PPD (last result with date)**

___________ **Current Laboratory Results (completed within prior 6 months)**

___________ **Hospitalization records from the past five years (if applicable)**

___________ **Documentation of Pneumococcal and Influenza Immunizations (if applicable)**

___________ **Dental Exam**

5425 Western Avenue, NW, Washington DC 20015
202.966.6667 • fax 202.362.0360 • www.lldhhome.org

The undersigned hereby makes application for admission to the Lisner-Louise-Dickson-Hurt Home.

IDENTIFYING INFORMATION
Name of applicant in full:

______________	______________	______________	______________
LAST	**FIRST**	**MIDDLE**	**MAIDEN**

Current Address: ______________________________ ______________________ ________ __________
STREET **CITY** **STATE** **ZIP**

Phone: ( ) _______---________________ Other: ( ) ________ --- ___________________

Date of Birth: _____/______/________ Age: ______________ Birthplace: ________________________________

Social Security Number: _______-_______-_________

Are you a United States Citizen? _____YES _____ NO

How long have you been a resident of the District of Columbia? ____________________________________

PRESENT LIVING ARRANGEMENT (Please select and provide additional information as necessary):

☐ Alone Do you have home health services? _____YES _____NO
☐ With Family Family Member's Name(s): ____
☐ With Friends Friend's Name(s): ____
☐ In an Assisted Living Center Name and Location: ____
☐ In a Nursing Facility Name and Location: ____
☐ Hospital Setting Name and Location: ____

APPLYING FOR: **_____COMMUNITY RESIDENTIAL FACILITY** **____ASSISTED LIVING RESIDENCE**
____ NURSING FACILITY **_____ SHORT TERM REHABILITATION**

ADDITIONAL CONTACT INFORMATION
Responsible Party:

Name: ____ Relationship: ___________________________

Address: ____ Phone: ( )___________________________

Name of two relatives or significant others:

Name: ____ Relationship: ___________________________

Address: ____ Phone: ( )___________________________

Name: ____ Relationship: ___________________________

Address: ____ Phone: ( )___________________________

Name of Applicant: ____

Who referred you to the Lisner-Louise-Dickson Hurt Home? ____

Please list your reason for application to the Home: ____

FAMILY AND SOCIAL HISTORY

Father's Name: ______________________________________

Mother's Name (First and Maiden Name): ____

Siblings:

Name(s)	Age(s) or "Older", "Younger"	Address(es)

MARITAL HISTORY(Please check appropriate box and include information for all previous marriages):

☐Married Date: ________________________ Date: ________________________

☐Widowed Date: ________________________ Date: ________________________

☐Separated Date: ________________________ Date: ________________________

☐Divorced Date: ________________________ Date: ________________________

☐Never married

Spouse's Name (include maiden name): ____

Spouse's Social Security Number: _____-_____-_______

CHILDREN:

Name(s)	Age(s)	Address(es)

Highest grade completed: ____________________

Name and location of last school attended: ____

Please list your primary occupation and other type of work done: ____

How may your spiritual needs be met and do you have a religious preference? ___________________________________

Please list your hobbies and interests and any organizations you belong to or have participated in:

Name of Applicant: ____

FUTURE PLANS AND ADVANCED DIRECTIVES

Do you have any money set aside for, or money invested in a burial plot, contract plan or arrangement to cover funeral or burial expenses? _______YES _______NO

If yes, please list the following information:

Owner: ____

Description: ____

Location: ____

Value: ____

*****Please include copies of any contracts or purchases for plots and services.**

Do you have a will? _______YES _______NO

If yes, please list the location of the will: ____

Executor's information: Name: ____

Address: ____

Phone: ____

Do you have any arrangements for organ donation? _______YES _______NO

If yes, please describe your arrangements (**include copies of prearranged agreements**): _________________

____

____

____

Do you have a **Living Will** for **health care** purposes? _______YES _______NO
(**If yes, please include a copy**)

Do you have a Durable Power of Attorney for **health care** purposes? ________YES ________NO
(**If yes, please include a copy**)

Do you have a Financial Power of Attorney? _______YES ________ NO
(If yes, please include a copy)

Name of Applicant: ____

FINANCIAL AND INSURANCE DATA: ***** Please note that copies of all insurance cards must be provided**

Do you have Medicare? __________ YES __________ NO

Medicare Number: ____________________________

Do you have Part A and Part B? __________________________

Dates Effective: Part A: _____________ Part B: _______________

Do you have District of Columbia Medicaid? __________ YES __________ NO

Medicaid Number: __________________________________

Do you have any additional medical insurance (i.e. Blue Cross/Blue Shield, AETNA etc.)? _____YES _____ NO

If yes, please include Insurance Type and Number: ______________________________

Do you have a life insurance policy/policies? __________ Yes __________ No

If yes, please complete the following and include copies of each policy including current value:

Name of Company:____

Policy Number: ____

Face Value: ____________________________________

Cash Value: ____________________________________

Date Issued: ____________________________________

Is the policy paid in full or are you continuing to make payments? ___________________________

Do you pay by check or is the payment automatically debited from your bank account?

____

In the table below, please include your present monthly income source (please include all sources i.e. Social Security; Retirement):

SOURCE	MONTHLY AMOUNT BEFORE DEDUCTIONS	IS AMOUNT DIRECTLY DEPOSITED TO YOUR BANK ACCOUNT?	CLAIM NUMBER

Name of Applicant: ____

ASSETS INFORMATION: ** Please note that current statements of value are needed for all assets**

Do you own property? __________ YES __________ NO

If yes, please complete the following:

Property Address: ____

Description /Value: ____

Income, if any received from the property: ____

Is there a joint owner? Please include name: ____

****** Because the Home is specifically for indigent residents of the District of Columbia, a property assessment is needed in order to determine eligibility for admission to the L-L-D-H Home.**

Do you own any stocks? __________ YES __________ NO

If yes, please complete the following:

Type/Description: ____

Value: ____

Income, if any received from stocks: ____

Is there a joint owner? Please include name: ____

Do you own any bonds? __________ YES __________ NO

If yes, please complete the following:

Type/Description: ____

Value: ____

Income, if any received from bonds: ____

Is there a joint owner? Please include name: ____

Do you have a Savings Account? __________ YES __________ NO

If yes, please complete the following:

Name of Bank: ____

Account Number: ____

Current Balance: ____

Is this a joint account? Please include name: ____

Is the account joint for management purposes only or does the account include both individuals funds? ____

Name of Applicant: ____

Do you have a Checking Account? __________ YES __________ NO

If yes, please complete the following:

Name of Bank: ____

Account Number: ____

Current Balance: ____

Is this a joint account? Please include name: ____

Is the account joint for management purposes only or does the account include both individuals funds? ____

Does your name appear on any bank accounts, which you consider to be someone else's? _____ YES _____ NO

If yes, please explain: ____

Do you have an accountant or other person who currently is managing your money? _____ YES _____ NO

If yes, please complete: **Name:** ____

Address: ____

Contact Number: ____

<u>THIRD PARTY REIMBURSEMENT:</u>

Have you ever applied for and received or applied for and been denied any public financial assistance, medical assistance or Supplemental Security Income? _____YES _____NO

If yes, please provide the dates: ____

Have you sold, transferred title or given as a gift any cash or property to any person within the last 24 months? _____YES _____NO

If yes, please discuss: ____

Have you ever been overpaid any SSI payments? _____YES _____NO

Are you currently receiving food stamps? _____YES _____NO

Have you received any wages in the past 14 months? _____YES _____NO

Were you self-employed in any of the past 12 months? _____YES _____NO

Do you have a safe deposit box? _____YES _____NO

Name of Applicant: ____

Have you or a former spouse ever:

	APPLICANT YES	APPLICANT NO	SPOUSE YES	SPOUSE NO
Been in the military?	____	____	______	______
Worked in the railroad service?	____	____	______	______
Worked for the Federal Government?	____	____	______	______
Worked for a State Government?	____	____	______	______
Worked for a County Government?	____	____	______	______
Worked for a City Government?	____	____	______	______
Worked for an employer with a pension plan?	____	____	______	______
Have you or anyone related to you by blood or marriage ever done work that was covered under the Social Security system or pension plan of a country other than the United States?	____	____	______	______

If yes, please provide the following:

Name of Employee: ____

ID or Claim Number if applicable: ______________________________________

Name and Address of Employer or Organization: ____________________________

____

Beginning and Ending Dates of Employment: ________________________________

____

By signing below, I certify that the information that I have provided is complete and correct to the best of my knowledge and belief.

______________________________________ ______________________

Applicant/Responsible Party **Date**