the Heritage at Lowman
Lutheran Homes of South Carolina

APPLICATION FOR ADMISSION

Active Lifestyle ▪ Assisted Living ▪ Rehabilitation and Healthcare

The Heritage at Lowman
Post Office Box 444
White Rock, SC 29177
803-732-8800

Application for Admission

the Heritage at Lowman
Lutheran Homes of South Carolina

Personal Information

Full Name: _____

Address: _____

Date of Birth: _____

Place of Birth:_____

Social Security Number:_____

Marital Status: _____ Spouse's Name: _____

Current or Previous Occupation: _____

Highest level of education attained: _____

Special Interests or Hobbies: _____

Please list below the names and relationship to applicant, complete addresses, home, office, and cell phone numbers of your family members or others who should be notified in case of emergency:

1. _____

_____

2. _____

_____

3. _____

_____

Do you have a Power of Attorney? Yes _____ No _____

Name of POA: _____Phone:_____

Address:_____

Do you have any of the following health care directives?

Health Care POA: _____ Living Will: _____ DNR: _____

The person responsible for handling my obligations or estate is:

Name: _____ Phone: _____

Address: _____

Applicant's Religious History

Member of what congregation: _____

Address:_____

Name of Pastor: _____ Phone:_____

Burial Arrangements

Funeral Home: _____

Address:_____

Phone: _____

I make this application to The Heritage at Lowman, White Rock, South Carolina, of my own free will and accord. I declare the answers to the foregoing questions to be true, full, and complete. I understand that giving false information may void my admission agreement.

_____

Your Signature Date

_____

Signature of Legal Guardian or POA Date

Accommodation Preferences

Please check preference:

- ❑ Rehabilitation and Healthcare Center
  - o Premium Private Room
  - o Private Room
  - o Companion Room
- ❑ Residential/Assisted Living
  - o Private Room/Bath
  - o Private Room/Shared Bath
- ❑ Active Lifestyle
  - o Boliek Apartments
    - ▪ Studio
    - ▪ One Bedroom
    - ▪ Two Bedroom
  - o Courtyards at Lowman Apartment Homes
  - o Traditional Garden Home
  - o Classic Garden Home (new construction)

Along with your application, please provide us with copies of the following:

- o Social Security Card (both sides)
- o Medical Insurance Cards (both sides)
- o Medicare Card
- o Advanced Healthcare Directives
- o Power of Attorney or Guardianship

** Please include $750 non-refundable community fee if applying for Residential/Assisted Living or Active Lifestyle.

Official Use Only:

Date Application Received:_____

Date Medical Information Received:_____

PHYSICIAN'S MEDICAL STATEMENT AND REPORT

the Heritage at Lowman
Lutheran Homes of South Carolina

Patient's Name: _____ **DOB:**_____

Date of physical examination (date must be within 30 days PRIOR to move in): _____

Code Status (please attach Rx and signed form ifDNR): _____

1. Current Diagnosis:
2. Physical Limitations:
3. Mental Health Limitations:
4. Treatment/Therapies (Describe medical service or nursing care needed. Attach a prescription.)
5. Supportive Services Needed:
6. Allergies:

Please attach current prescriptions your patient is receiving so we may order the correct medications. **Also include any PRN or OTC medications** they are taking as we are unable to allow any medications without written physician prescriptions in assisted living.

MEDICATION	DOSE	ROUTE	TIME TO BE GIVEN

DIET INSTRUCTIONS:_____Regular Diet ____No Added Salt ____Low Concentrated Sweets

_____Pureed _____Mechanical Soft, Chopped _____No Fried Foods

STATUS OF THE FOLLOWING:

AMBULATING	**BATHING**	**DRESSING**	**EATING**
__Independent	__Independent	__Independent	__Independent
__Needs supervision	__Needs reminders	__Needs reminders	__Needs prompting
__Hands on assist	__Monitor/Supervise/Cue	__Lay out articles	__Minimal assistance
__Uses cane/walker/wheelchair	__Set up for bathing	__Minor assist (buttons, laces)	__Finger foods/Cut
__Needs assistance transferring	__Assist in/out of shower	__Full assistance needed	__Spoon fed
	__Assist with certain areas		
	__Full assistance needed		

Patient's Name: _____

GROOMING	TOILETING	MOBILITY	MEDICATION
_Independent	_Independent	_Independent	_Self-Medicates
_Needs reminders/cues	_Needs reminders/cues	_Needs Supervision	__Staff administer meds
_Set up for grooming	_Incontinent with self-care	_Needs Assist of 1	
_Full assistance	_Incontinent/total assistance	_Uses walker	
		_Uses wheelchair	

Please read carefully and initial each of the following ONLY IF APPROPRIATE:

_____ The individual's behavior does **not** pose a danger to self or others.

_____ The individual **DOES NOT** need 24 hour RN or LPN supervision (as in a skilled nursing home or hospital).

_____ Based on the type of care the staff of an Assisted Living may legally provide, the **individual's needs can be met in an Assisted Living Community** for adults that is not a skilled nursing home.

_____ The individual is free from signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.

_____ Considering the cognitive limitations, it is my opinion that this individual requires a **secured (locked) dementia** care unit.

_____ The individual is able to safely maintain and control the security of common household cleaning chemicals and personal grooming supplies in his/her own room.

_____ The individual is able to safely maintain over-the-counter medications in his/her own room and may self-medicate OTC's at their own discretion.

_____ The individual is able to participate in supervised food preparation activities at will.

_____ The individual is able to make food choices outside of any diet order/restrictions.

STATE REQUIREMENT FOR ADMISSION TO ASSISTED LIVING COMMUNITY:

PLEASE NOTE: PERSON PLACING PPD MUST BE LICENSED MEDICAL PROFESSIONAL – LPN, RN, NP, PA, or MD

Date 1st step PPD given: _____ **Date 1st step PPD read:** _____ **Results of 1st step PPD:** _____**mm.**
LOT #:_____ **Exp. Date:**_____ **Person Placing PPD:** _____ **Person Reading PPD:** _____

2nd step may be given at the Heritage at Lowman if admitted within 21 days from the 1st step.
If not admitted, then 2nd step must be given at physician's office within 7-21 days of 1st step.

Date 2nd step PPD given: _____ **Date 2nd step PPD read:** _____ **Results of 2nd step PPD:** _____**mm.**
LOT #:_____ **Exp. Date:**_____ **Person Placing PPD:** _____ **Person Reading PPD:** _____

X-Ray results if resident known positive: _____ **(Attach report as necessary).**

I understand that assisted living residences are built in accordance with modern life safety and disability construction codes and fire protection requirements. In my opinion, this individual is capable of self-preservation with minimal human assistance (no more than 1 person) in an emergency involving the immediate evacuation of the facility.

Physician's Printed Name: _____ **Physician Signature:** _____

Address: _____

Telephone: _____ **Fax:** _____**Date Signed:** _____

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CONFIDENTIAL FINANCIAL DISCLOSURE FORM

This form is designed to enable you and Lutheran Homes of South Carolina to determine your ability to meet the financial requirements for residency.

Date of Application: _____

Applicant's Name: _____	Date of Birth: _____
Spouse's Name: _____	Date of Birth: _____
Address _____	Telephone: (Home) _____
City/State/Zip _____	(Mobile) _____

ASSETS

	Applicant	Spouse
Checking Account	$ _____	$ _____
Savings Account	$ _____	$ _____
Money Market Account	$ _____	$ _____
Certificates of Deposit	$ _____	$ _____
Investments (Stocks, Bonds, Etc.)	$ _____	$ _____
Pensions/Annuities (cash value)	$ _____	$ _____
IRAs (cash value)	$ _____	$ _____
Funds in Trust	$ _____	$ _____
Life Insurance (cash value)	$ _____	$ _____
Home (cash value)	$ _____	$ _____
Other Real Estate	$ _____	$ _____

Type of Properties Owned _____

Do you have full ownership? _____

Other Assets	$ _____	$ _____

Please Explain _____

Total Assets:	**$** _____	**$** _____

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CONFIDENTIAL FINANCIAL DISCLOSURE FORM

LIABILITIES

	Applicant	Spouse
Home Mortgage Balance.....	$ _____	$ _____
Other Mortgage Balances.....	$ _____	$ _____
Vehicle Loan Balance.....	$ _____	$ _____
Credit Card Balances.....	$ _____	$ _____
Loan Balances.....	$ _____	$ _____
Other Liabilities	$ _____	$ _____

Please Explain _____

Total Liabilities: **$** _____ **$** _____

MONTHLY INCOME

	Applicant	Spouse
Social Security.....	$ _____	$ _____
Pension/Annuity Income.....	$ _____	$ _____

Does Pension Provide a Surviving Spouse Benefit? _____

IRA Distributions.....	$ _____	$ _____
VA Benefits.....	$ _____	$ _____
Rental Income.....	$ _____	$ _____
Dividend/Interest Income.....	$ _____	$ _____
Other Income.....	$ _____	$ _____

Please Explain _____

Total Monthly Income: **$** _____ **$** _____

If necessary, please provide any further information:

_____

_____

_____

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CONFIDENTIAL FINANCIAL DISCLOSURE FORM

MONTHLY EXPENSES

	Applicant	Spouse
Home Mortgage (Including taxes and insurance)…	$ _____	$ _____
Is it a reverse mortgage? _____		
Other Mortgage Payments……	$ _____	$ _____
Vehicle Payments……	$ _____	$ _____
Credit Card Payments……	$ _____	$ _____
Bank and Loan Installment Payments……	$ _____	$ _____
Utilities……	$ _____	$ _____
Household Expenses……	$ _____	$ _____
Pharmacy……	$ _____	$ _____
Insurance Premiums……	$ _____	$ _____
Other Expenses……	$ _____	$ _____
Please Explain _____		
Total Monthly Expenses:	**$** _____	**$** _____

THIRD PARTY PAYER INFORMATION

Applicant:
Primary Insurance Company:
_____
Policy # _____
Supplemental Insurance Company:
_____
Policy # _____
Medicare A # _____
Medicare B # _____
Medicare Part D Prescription Information:
Company _____ Group # _____
Medicaid # _____

Spouse:
Primary Insurance Company:
_____
Policy # _____
Supplemental Insurance Company:
_____
Policy # _____
Medicare A # _____
Medicare B # _____
Medicare Part D Prescription Information:
Company: _____ Group # _____
Medicaid # _____

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CONFIDENTIAL FINANCIAL DISCLOSURE FORM

LONG-TERM CARE INSURANCE

If you or your spouse have long-term care insurance, please provide the following information:

Applicant
Company: _____
Policy #: _____

Amount Covered Daily:
Assisted Living _____
Skilled Care _____
Home Care _____

Waiting Period:
Assisted Living _____
Skilled Care _____
Home Care _____

Amount Previously Utilized in Each Area:
Assisted Living _____
Skilled Care _____
Home Care _____

Maximum Amount to be Paid:
Assisted Living _____
Skilled Care _____
Home Care _____

Spouse
Company: _____
Policy #: _____

Amount Covered Daily:
Assisted Living _____
Skilled Care _____
Home Care _____

Waiting Period:
Assisted Living _____
Skilled Care _____
Home Care _____

Amount Previously Utilized in Each Area:
Assisted Living _____
Skilled Care _____
Home Care _____

Maximum Amount to be Paid:
Assisted Living _____
Skilled Care _____
Home Care _____

I affirm that this information is substantially complete and correct to the best of my knowledge.

Signature_____
Date_____

Signature_____
Date_____

If prepared by a person or firm other than applicant, please note:

Name_____
Address_____

Telephone_____
City/State/Zip_____

OFFICE USE ONLY
Name of Applicant_____
Name of Spouse_____
Entrance Fee_____
Community_____

Entry Level:
_____
_____
Monthly Service Fee_____
Received By_____

Level of Care:
_____
_____
Date_____