Trinity
on Laurens
Lutheran Homes of South Carolina

213 LAURENS STREET NW
AIKEN, SC 29801

APPLICATION FOR RESIDENCY

A MINISTRY OF THE EVANGELICAL LUTHERAN CHURCH IN AMERICA
OUR MISSION IS TO PROMOTE THE WELLBEING OF OLDER ADULTS

Date of Reservation ________ Date Received ________ Date Approved ________

APPLICATION FOR RESIDENCY

Please complete and return: the Application for Residency and Confidential Financial Statement. This information is kept strictly confidential. For couples, each individual will need to complete an application for residency and confidential financial statement. Please return this completed application by: ____________

Your Full Name ______________________________ Social Security No. ____________

Marital Status ________ Date of Marriage ________ Date of Spouse's Death (if applicable) ________
Single, Married, Divorced, Widowed

Spouse's Name ______________________________

Present Address (Street) ______________________________

City, State, Zip ______________________________ Telephone No. ____________

Date/Place of Birth ______________________________

How many years at present address? ________ Do you ❑ Own home ❑ Rent ❑ Live with children ❑ Other: ________

Do you manage your own financial and legal matters? ❑ Yes ❑ No

Do you have a ❑ bank, ❑ trust department or ❑ other person to manage your financial affairs? ❑ Yes ❑ No

Present and/or former occupation ______________________________

Educational background ______________________________

Hobbies and interests ______________________________

Church, community and/or civic organizations to which you belong or have belonged ____________

____

Church affiliation ______________________________

Minister's name & Church (please list address and phone no.) ____________

____

In your estimation, is your health good, fair, or poor? ____________

Do you have any specific physical limitation? ____________

PHYSICIAN

Physician's name, address and telephone number: ____________

____

INSURANCE

Do you have insurance coverage under Medicare?

Part A ❑ Yes ❑ No If yes, number ____________ Part B ❑ Yes ❑ No If yes, number ____________

Do you have supplemental insurance coverage? ❑ Yes ❑ No

If yes, company name and policy number ____________

Do you have other health or accident insurance policies? ❑ Yes ❑ No

If yes, name and description of insurance ____________ Policy no. ____________

CHILDREN

Provide the following for each of your children: name, address, work and home telephone numbers:

____

____

____

____

TYPE OF RESIDENCE

I prefer a: ❑ One-bedroom apartment ❑ Two-bedroom apartment

EMERGENCY

In case of emergency, please contact/do not contact the following people: (Please provide name, relationship, work and home telephone numbers):

1. ____________ ❑ Contact ❑ Do Not Contact
2. ____________ ❑ Contact ❑ Do Not Contact
3. ____________ ❑ Contact ❑ Do Not Contact

____________ Applicant's Signature (self)

____________ Printed Name (self)

____________ Legal Guardian or Power of Attorney Signature

____________ Printed Name (Legal Guardian or Power of Attorney)

____________ Date

Lutheran Homes of South Carolina Referral Information Sheet

1. How did you learn about LHSC?____
____

2. Who, if anyone, specifically referred you to LHSC?____________________
____

   a. If someone referred you to Trinity, what is the relationship of the person who referred you to LHSC: (circle)
      i. She/he is my Pastor, Family, Friend, Physician, Professional
      ii. She/he is an LHSC employee or resident
      iii. She/he is (other, specify)________________________________

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? ________

	Applicant	Spouse
Other Assets…………………………………	$ ________	$ ________

Please Explain ________________________________

	Applicant	Spouse
Total Assets:	**$** ________	**$** ________

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:

____

____

____

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 # ________________

CONFIDENTIAL FINANCIAL DISCLOSURE FORM

LONG-TERM CARE INSURANCE

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

Applicant	Spouse
Company: ____________	Company: ____________
Policy #: ____________	Policy #: ____________
Amount Covered Daily:	Amount Covered Daily:
Assisted Living ________	Assisted Living ________
Skilled Care ________	Skilled Care ________
Home Care ________	Home Care ________
Waiting Period:	Waiting Period:
Assisted Living ________	Assisted Living ________
Skilled Care ________	Skilled Care ________
Home Care ________	Home Care ________
Amount Previously Utilized in Each Area:	Amount Previously Utilized in Each Area:
Assisted Living ________	Assisted Living ________
Skilled Care ________	Skilled Care ________
Home Care ________	Home Care ________
Maximum Amount to be Paid:	Maximum Amount to be Paid:
Assisted Living ________	Assisted Living ________
Skilled Care ________	Skilled Care ________
Home Care ________	Home Care ________

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

Signature____________	Signature____________
Date____________	Date____________

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

Name____________	Telephone____________
Address____________	City/State/Zip____________

OFFICE USE ONLY
Name of Applicant____________
Name of Spouse____________
Entrance Fee____________
Community____________ Received By____________ Date____________
Entry Level: ________ ________
Level of Care: ________ ________
Monthly Service Fee____________