Application for Admission
St. Luke Homes & Services, Inc.

St Luke Lutheran Home
1301 St Luke Dr
Spencer, IA 51301
712-262-5931

The Highlands
1211 St Luke Dr
Spencer, IA 51301
712-262-5404

Riverview Terrace
1501 St Luke Dr
Spencer, IA 51301
712-262-5932

South Ridge Heights
1209 12th St. SE
Spencer, IA 51301
712-262-5934

Admissions, room assignments and services are provided without regard to race, color, national origin, religion, sex, age, creed, physical disability, political belief, providing we can meet the needs of those requiring our services.

All information provided by applicant will be held in strict confidence.

I hereby apply for admission as a resident/tenant/homeowner of St. Luke Homes & Services, Inc.

PERSONAL INFORMATION

Legal Name_____
(as stated on Medicare Card) (LAST) (FIRST) (Middle) (Maiden Name)

Preferred Name:_____ Phone No._____

Present Address:_____
(STREET) (CITY) (STATE) (ZIP)

Date of Birth:_____ Birth Place:_____
(CITY, COUNTY, STATE)

MILITARY STATUS

Are you a Veteran?_____ Was your spouse a Veteran?_____

Branch of Military:_____ War:_____

Education Level:_____ Previous Occupation:_____

RELATIONSHIP STATUS and CHURCH MEMBERSHIP

☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse or Partner:_____ Date of Marriage:_____

If spouse is deceased, give date of death:_____ Religious Preference:_____

Church Membership:_____
(optional) (NAME OF CHURCH) (COMPLETE ADDRESS) (PHONE)

Number of children born:_____ *List living children below.

(NAME) (COMPLETE ADDRESS, INCLUDING ZIP CODE) (PHONE NO.)

_____

_____

_____

_____

_____

_____

MEDICAL PROVIDERS

Pharmacy:

Nursing Home/Assisted Living with **Managed** Medication Distribution:

☐ White Drug ☐ HyVee ☐ VA Meds &_____(please list secondary)

Assisted Living **Non-Managed** Medication Options:

☐ White Drug ☐ HyVee ☐ Walmart ☐ Other_____

Physician:_____

(NAME) (ADDRESS) (PHONE)

Dentist:_____

(NAME) (ADDRESS) (PHONE)

Optometrist:_____

(NAME) (ADDRESS) (PHONE)

Ophthalmologist:_____

(NAME) (ADDRESS) (PHONE)

Audiologist:_____

(NAME) (ADDRESS) (PHONE)

Podiatrist:_____

(NAME) (ADDRESS) (PHONE)

Other Specialist:_____

(NAME) (ADDRESS) (PHONE)

Other Specialist:_____

(NAME) (ADDRESS) (PHONE)

Medical Supplier preference (Assisted Living):

☐ NW Respiratory ☐ LinCare ☐ Avera Medical ☐ Other_____

(NAME, ADDRESS, PHONE)

Financial coverage of cost:

☐ Title 19 ☐ Title Pending ☐ VA Contract ☐ Private ☐ Long Term Care Policy & Private ☐ Elderly Waiver (Assisted Living)

Payment of the *monthly billing statement*, and the *receipt of business mail* is the responsibility of:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Email: _____

TITLE: ☐ Social Security Payee ☐ Power of Attorney (POA) ☐ Conservator ☐ Other

**Would you prefer to receive monthly statements by email? _____

Who is to be notified in case of an emergency? List at least 2 contacts in the order in which they are to be notified.

H= home phone C= cell phone W=work phone

1) Name: _____ Relationship: _____
Address: _____ Primary Phone: _____ H C W
_____ Phone: _____ H C W
Email: _____ Phone: _____ H C W

2) Name: _____ Relationship: _____
Address: _____ Primary Phone: _____ H C W
_____ Phone: _____ H C W
Email: _____ Phone: _____ H C W

3) Name: _____ Relationship: _____
Address: _____ Primary Phone: _____ H C W
_____ Phone: _____ H C W
Email: _____ Phone: _____ H C W

4) Name: _____ Relationship: _____
Address: _____ Primary Phone: _____ H C W
_____ Phone: _____ H C W
Email: _____ Phone: _____ H C W

Have you resided in another assisted living/nursing home within the last 5 years?_____

Check which documents do you currently have: *(Please provide copies)*

☐ Living Will ☐ Durable Power of Attorney for Health Care ☐ Guardianship/Conservatorship

Executor Information:_____
(NAME) (COMPLETE ADDRESS INCLUDING ZIP) (PHONE)

Funeral Home Preference:_____
(NAME) (ADDRESS) (PHONE)

INSURANCE COVERAGE: *(please provide copies of all cards)*

Social Security No._____ Medicare Part D Plan:_____

Medicare No._____ Medicare Advantage Plan:_____

Medicaid No._____ Manage Care Company:_____

Supplemental Health:

Provider Name:_____
Policy Number:_____
Provider Name:_____
Policy Number:_____

Long Term Care Plan:

Provider Name:_____
Policy Number:_____
Provider Name:_____
Policy Number:_____

**How long do you estimate your personal resources will be sufficient to provide for your care and residency?

***Please refer to attached Appendix A to help you.

_____
Signature of Applicant or Responsible Party

_____
Date