Good SHEPHERD
A Community For All Ages

APPLICATION FOR ADMISSION

Thank you for your interest in Good Shepherd Services. In order to be considered for residency or placed on our waiting list, it will be necessary to complete this preliminary application. Please return the completed application to Deb Captain at the main Good Shepherd campus located at 607 E. Bronson Rd., Seymour, WI 54165. **All information is kept strictly confidential**.

Please check which facility you are applying to:

☐ Birch Way Residential Assisted Living

607 E. Bronson Rd.

Seymour, WI 54165

(920) 833-6856

☐ Shepherd's Inn Residential Assisted Living

621 Factory Street

Seymour, WI 54165

(920) 833-2013

☐ Good Shepherd Nursing Home

607 E. Bronson Rd.

Seymour, WI 54165

(920) 833-6856

☐ Forest Glen Residential Assisted Living

721 E. Bronson Rd.

Seymour, WI 54165

(920) 833-6856

Applicant(s) Name: _____

Address: _____

Sex: ☐ M ☐ F Marital Status: _____ Birthdate: _____Birth County& State: _____

Social Security Number: _____ Phone Number: _____

Church: _____ Funeral Home: _____

Physician: _____

Dentist: _____

Past or present occupation: _____ Military: (Applicant or Spouse) _____

Eye Doctor: _____

List Applicant(s) current diagnosis: _____

_____

_____

_____

List Applicant(s) current medications: _____

_____

_____

_____

Describe Applicant(s) current needs (i.e. physical needs, medication management, supervision, ect):

_____

_____

_____

_____

Check all that are appropriate: **(If applicable PLEASE PROVIDE Good Shepherd Services WITH A COPY):**

Does the Applicant(s) have a Durable Power of Attorney? Yes ☐ No ☐

Has the Durable Power of Attorney been activated? Yes Activated ☐ Not Activated ☐

Does the Applicant have a Living Will? Yes ☐ No ☐

Does the Applicant have a Legal Guardian? Yes ☐ No ☐

If so, please provide the Legal Guardian's name _____

Who to contact in case of emergency:

1. Name: _____

Address: _____

Phone: _____

Relationship: _____

2. Name: _____

Address: _____

Phone: _____

Relationship: _____

3. Name: _____

Address: _____

Phone: _____

Relationship: _____

4. Name: _____

Address: _____

Phone: _____

Relationship: _____

Health Insurance Information

Medicare #:_____ Part A ☐ Part B ☐

Medical Assistance #:_____ Effective date: _____

Assisted Living Insurance Company: _____

Policy #:_____ Group #: _____

Health Insurance Company: _____

Policy #:_____

Does Applicant have Medical Assistance/Medicaid/T19? Yes ☐ No ☐
Medical Assistance Number: _____

Does Applicant have Long Term Care Insurance? Yes ☐ No ☐
Name & Phone Number of Insurance Company: _____
_____

Does the Applicant have Prescription Drug Coverage? Yes ☐ No ☐
Name & Phone Number of Insurance Company: _____
_____

INCOME

Monthly Income	Applicant (per month)	Spouse (per month)
Social Security		
Veteran's Benefits		
SSI Supplement Security Income		
Pension		
Retirement Plans		
Disability Plans		
Income for Stocks & Bonds		
Rental Income Paid to You		
Annuities		
Trust Fund		
Interest Income for Savings		
Other: _____ _____	_____ _____	_____ _____
Total Monthly Income		

LIABILITIES

Liabilities	Yes	No	Amount
Taxes			
Medical Bills			
Loans (description) _____ _____			
Health Insurance Costs			
Other (description) _____ _____			

ASSETS

Assets	Yes	No	Who owns (resident, spouse, joint) If joint name co-owner	Amount/ Value
Life Insurance Company Name: _____ Cash Value_____ Face Value_____ Date Issued_____				
Checking Account Name of Bank: _____				
Savings Account Name of Bank: _____				
Stocks				
Bonds				
Certificates of Deposit				
Do you own your residence?				
Land Contract				

Assets	Yes	No	Who owns (resident, spouse, joint) If joint name co-owner	Amount/Value
Do you have a Burial Trust?				
Other Assets Description: _____ _____				

ASSETS SOLD OR GIVEN AWAY WITHIN THE LAST 5 YEARS:

Description of what sold or given away: _____
_____

By Whom: _____

To Whom: _____

Date of gift or sale: _____ Total Market Value: _____

Amount Received: _____

I understand and agree that the forgoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Residency Agreement has been signed by the parties hereto.

NURSING HOME ONLY: Private pay residents are required to pay for services one month in advance. First month care services fee will be required at the time of admission. In the event a pay source is not available or benefits cannot be authorized, residents will be considered private pay until an alternate pay source can be confirmed.

I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

_____ _____
Signature of Applicant Date

OR

_____ _____
Signature of person completing the form Date

Address: _____ Phone Number: (_____)_____