PHYSICIAN'S MEDICAL STATEMENT AND REPORT

On _____, I performed a physical examination of _____(must be within 30 days PRIOR to move in).

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:
7. Current Medications: (Current Signed Prescriptions may be attached)

PLEASE ATTACH CURRENT PRESCRIPTIONS YOUR PATIENT IS RECEIVING SO THAT WE MAY ORDER THE CORRECT MEDICATIONS, (IF YOU R PATIENT IS NOT ABLE TO SELF-MEDICATE). PLEASE INCLUDE ANY PRN OR OTC'S THAT HE/SHE MAY TAKE AS WE ARE UNABLE TO ASSIST OR ALLOW ANY MEDICATIONS WITHOUT A WRITTEN PHYSICIAN PRESCRIPTION IN ASSISTED LIVING.

MEDICATION	DOSE	ROUTE	TIME TO BE GIVEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DIET INSTRUCTIONS: ___Regular Diet ___No Added Salt ___No Conc. Sweets

STATUS OF THE FOLLOWING:

AMULATING
__Independent
__Needs Supervision
__Needs Assist of 1

BATHING
__Independent
__Needs Supervision
__Needs Assist of 1

DRESSING
__Independent
__Needs Supervision
__Needs Assist of 1

EATING
__Independent
__Needs Supervision
__Needs Assist of 1

GROOMING
__Independent
__Needs Supervision
__Needs Assist of 1

TOILETING
__Independent
__Needs Supervision
__Needs Assist of 1

MOBILITY
__Independent
__Needs Supervision
__Needs Assist of 1

MEDICATION
__Self-Medicate
__Needs Assistance

Doctor, 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 is able to participate in supervised food preparation activities at will.

_____ 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.

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

_____ 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.

_____ Individual is able to safely maintain and control security common of household cleaning chemicals and personal grooming supplies in own room/apartment.

_____ Individual is able to safely maintain over-the-counter medication in own room/apartment and may self-medicate OTC's at own discretion. (Order to be renewed every 6 months).

Weight: _____ Temp: _____ B/P: _____ P: _____ R: _____

Hospital Preference: _____ Nursing Home Preference: _____

Funeral Home Preference: _____

STATE REQUIRED FOR ADMISSION TO ASSISTED LIVING COMMUNITY

Date 1st Step PPD Given: _____ **Date 1st step PPD read:** _____ **Results of 1st step PPD:** _____

2nd STEP TO BE DONE AT LUTHERAN HOMES OF SC COMMUNITY:

Date 2nd step PPD given _____ **Date 2nd step PPD read:** _____ **Results of 2nd step PPD:** _____

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

I understand that assisted living residences are built to 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:** _____

Please return report/information to:

Community Name: RoseCrest Retirement Community **Contact Person:** Admissions Coordinator

Address: 200 Fortress Drive Inman, SC 29349

Phone: 864-599-8600 **Fax:** 864-599-8604 or 864-578-4224

AUTHORIZATION OF DO NOT RESUSITATE
RESIDENT WITH DECISION MAKING CAPACITY

I _____,have been informed of and understand the risks and benefits of Cardiopulmonary Resuscitation (CPR) and hereby request that CPR not be initiated in the event of cardiopulmonary arrest.

_____ _____
Resident's Signature Date

I, as the attending physician of this resident, have explained the consequences of an order not to resuscitate, including the potential benefits and disadvantages of such an order. Furthermore, I have determined that the resident has the ability to understand and appreciate the nature of their decision in this matter.

_____ _____
Physician's Signature Date

AUTHORIZATION OF DO NOT RESUSCITATE
RESIDENT WITHOUT DECISION MAKING CAPACITY

As the attending physician of, _____, I hereby authorize the entry of an order in the medical record instruction this facility not to provide Cardiopulmonary Resuscitation (CPR) or Intubation to this resident. Please check the appropriate category below:

____(a) The resident has a medical condition that can be expected to result in the imminent death of the resident.
____(b) The resident is in a non-cognitive state with no reasonable possibility of regaining cognitive functions.
____(c) The resident is a person for who Cardiopulmonary Resuscitation would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function; or would only restore cardiac and respiratory functioning for a brief period of time so that the resident will likely experience repeated need for cardiopulmonary resuscitation over a short period of time.
____(d) See Physician H&P

_____ _____
Attending Physician Signature Date

I concur with the above decision that the this Resident is a candidate for no resuscitation.

_____ _____
Concurring Physician Signature Date

As the Authorized Person, I consent to the order not to resuscitate this Resident. As I believe he/she would have wanted under the circumstances being considered.

_____ _____
Authorized Person Signature/Relationship Date

_____ _____
Witness Date

D H E C

PROMOTE PROTECT PROSPER

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

RESUSCITATE

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____ that he/she has a terminal condition which has been diagnosed by me and has
(Name of Patient)

specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MULTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date _____ Patient's Signature (or Surrogate or Agent) _____

Physician's Name (Please Print) _____ Physician's Signature _____

Physician's Address _____ Physician's Telephone Number _____

Application for Residency

Blending Southern Tradition with Abundant Living

Date of Reservation _____ Date Received _____ Date Approved _____

APPLICATION FOR RESIDENCY

Please complete and return this Application for Residency and the accompanying Confidential Disclosure Form. This information is kept strictly confidential. For couples, each individual will need to complete an application for residency, however the Confidential Financial Disclosure Form may be completed jointly. Please return this completed application by ____/____/____.

PERSONAL INFORMATION

Full Name (Last, First, middle) _____ SS # _____-_____-_____

Address: _____City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

How many years at present address? _____ Do you ❑Own home ❑Rent ❑Live with Children ❑Other _____

Maiden Name (if applicable): _____

Date of Birth: _____ Place of Birth (city, state and country): _____

Mother's Maiden Name _____ Father's Full Name _____

Marital Status: _____ Date of Marriage: _____ Spouse's Name: _____
(Single, married, divorced, widowed)

Present and/or Previous Occupation: _____

Educational Background:

_____

Special Interests or Hobbies: _____ Do you own a pet? _____

Religious Preference: _____ Name of Church/Synagogue/Mosque : _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact(s) : _____ Phone(s): _____

CHILDREN *(Use additional sheet if necessary)*

Name	Address	Phone	Cell	E-mail
1.				
2.				
3.				

WELLNESS

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

Do you have any specific physical limitations? _____

Have you been diagnosed with a specific condition or disease? _____

Primary physician's name: _____ Area of Specialty (if applicable) _____

Address: _____ City: _____ State: _____ Zip: _____

Phone(s): _____ Fax: _____

EMERGENCY

Below, please list names, complete addresses and all phone numbers for family members to be notified in case of an emergency: (Please attach separate sheet if needed.)

Relationship Name Complete Address Phone number (s)

1. _____

2. _____

3. _____

LEGAL

Who, if anyone besides yourself, is responsible for your legal and financial obligations and/or estate matters?

Name: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Do you have a General/Healthcare Power of Attorney? Yes _____ No _____

Name: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Alternate phone: _____

How did you learn about our community and/or Lutheran Homes of SC ? _____

_____

_____

Who, if anyone, specifically referred you to our community and/or Lutheran Homes of SC ? (check all that apply)

❑Newspaper ❑Internet ❑Friend/Family ❑Radio

❑Health Care Provider ❑Legal/Financial Planner ❑Clergy ❑Other (please explain below)

_____

_____

_____

SIGNATURES

_____ _____

Applicant's Signature (self) Printed Name (self)

Date _____

_____ _____

Power of Attorney Signature (if applicable) Printed Name (Power of Attorney)

Date _____

Lutheran Homes of South Carolina

promoting the well-being of older adults

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:	$ _____	$ _____

Lutheran Homes of South Carolina

promoting the well-being of older adults

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:

_____

_____

_____

Lutheran Homes of South Carolina

promoting the well-being of older adults

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 # _____

Lutheran Homes of South Carolina

promoting the well-being of older adults

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		Entry Level:	Level of Care:
Name of Applicant_____		_____	_____
Name of Spouse_____		_____	_____
Entrance Fee_____		Monthly Service Fee_____	
Community	Received By		Date