



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

St. Luke Lutheran Nursing Home
1301 St. Luke Drive
Spencer, IA. 51301
712-262-5931

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

Hillside Terrace
1209 12th St. S.E.
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 of St. Luke Homes & Services, Inc. *(Please answer all questions.)*

1. Name: _____
(Last) (First) (Middle) (Maiden Name)

2. Present Address: _____
(Street) (City) (State) (Zip Code)

3. Social Security No. _____ Phone No. _____
Medicare No. _____ Medicaid No. _____
(Copy of card needed) (Title XIX)

4. Date of Birth: _____ Place of Birth: _____

5. Are you a Veteran? _____ Was your spouse a Veteran? _____
If either answered Yes, please give Dates of Services for the Veteran: Entered: _____ D'chrg: _____
Branch of Military: _____ War: _____

Married Status: Single Married Widowed Divorced

7. Name of Husband or Wife: _____ Date of Marriage: _____

8. If spouse is deceased, give date of death: _____

9. Applicant's previous occupation: _____ Year retired: _____

10. Spouse's occupation: _____

11. Number of children born: _____ *List living children below.
(Name) (Complete Address, Including Zip Code) (Phone No.)

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

13. Religious Preference: *This question is optional

a. Church Membership: _____

(Name of Church)

(Complete Address)

(Phone)

b. If you do not have church membership, do you have a religious preference: _____
If yes, what is your preference?

c. Do you wish for your minister to be notified for your admission? YES Not Necessary

d. Minister's Name: _____

14. Financial coverage of cost: Private Title XIX Long term care policy Elderly Waiver

15. Nursing Home or Health Insurance Policies, other than Medicare (copy of card needed):

Company Name:

Type of Insurance:

Policy No.:

16.

To whom should monthly statements, business mail, etc., be sent? Applicant Other

If other, please list name and address: _____

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

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

17. Who is to be notified **in case of an emergency**? List at least two in the order they are to be notified.

(1.) Name: _____ Relationship: _____

Address: _____ Home phone: _____ Work phone: _____

_____ Cell phone: _____ Email: _____

(2.) Name: _____ Relationship: _____

Address: _____ Home phone: _____ Work phone: _____

_____ Cell phone: _____ Email: _____

(3.) Name: _____ Relationship: _____

Address: _____ Home phone: _____ Work phone: _____

_____ Cell phone: _____ Email: _____

(4.) Name: _____ Relationship: _____

Address: _____ Home phone: _____ Work phone: _____

_____ Cell phone: _____ Email: _____

