



# Lasata Care Center Application for Residency

\*Application Instructions\*

1. Save to your computer
2. Fill out application and save
3. Submit application via email below.

This Section For Official Use Only

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Date Received

Admission Date

Payment Source

Doctor at Lasata

Unit  Room

Resident Number

Admitted From

Long Term      Short Term

## Personal Information

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First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Maiden Name \_\_\_\_\_

Likes to be Called \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Phone Number \_\_\_\_\_

SSN \_\_\_\_\_

Date of Birth    Month \_\_\_\_\_    Day \_\_\_\_\_    Year \_\_\_\_\_

Place of Birth \_\_\_\_\_

Marital Status \_\_\_\_\_

Sex            Male                                  Female

Church Affiliation \_\_\_\_\_

Address \_\_\_\_\_

City                                  State                                  Zip Code

Do you have a funeral Trust?            Yes                                  No

Funeral Home \_\_\_\_\_

Years of residency (as an adult) in Ozaukee County \_\_\_\_\_

Have you ever been to Lasata Care Center before? \_\_\_\_\_

Another Facility? \_\_\_\_\_

Out of County Applicants: If you do not meet the residency requirement (currently living in Ozaukee County for at least 1 year), indicate the name and address of an immediate relative who does meet the residency requirement:

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Address \_\_\_\_\_

City                                  State                                  Zip Code

Years in Ozaukee County \_\_\_\_\_

**Insurance Information**

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Medicare Number \_\_\_\_\_

Supplemental Insurance \_\_\_\_\_

Supplemental Insurance ID# \_\_\_\_\_

Long Term Care Insurance \_\_\_\_\_

Long Term Care Insurance ID # \_\_\_\_\_

Title 19 - Medical Assistance # \_\_\_\_\_

## Prescription Insurance

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Company  
Name

\_\_\_\_\_

Member ID

RxPCN

\_\_\_\_\_

RxBin

RxGRP

\_\_\_\_\_

## Medical Information

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Primary Physician

\_\_\_\_\_

Address

\_\_\_\_\_

City

State

Zip Code

\_\_\_\_\_

Phone

\_\_\_\_\_

Other Physician

\_\_\_\_\_

Specialty

\_\_\_\_\_

Phone

\_\_\_\_\_

Dentist

\_\_\_\_\_

Address

\_\_\_\_\_

City

State

Zip Code

\_\_\_\_\_

Hospital  
Preference

\_\_\_\_\_

Pharmacy Preference

\_\_\_\_\_

## Social History

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Your profession  
or occupation  
before retiring

Were you in military  
service?

Yes

No

If so, which branch?

## Power of Attorney

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Do you have a Power  
of Attorney?

Yes

No

If Yes

Heath Care

Finance

Both

Has it been activated?

Yes

No

If Yes

Heath Care

Finance

Both

Do you have a  
legal Guardian?

Yes

No

## Confidential Financial Information

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This confidential financial information will be used in determining your ability to meet financial obligations. It is used solely by Lasata Senior Living Campus.

**Please list all assets** Add together multiple accounts

Real Estate	Estimated Market Value	_____	Amount of mortgage	_____
Checking Accounts - Approximate Amount		_____		
Savings or Money Market Accounts - Approximate Amount		_____		
Certificate of Deposit - Approximate Amount		_____		
Stocks and Bonds - Total Approximate Value		_____		
Total Assets	_____			

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### Monthly Income

Social Security	_____	Interest	_____
Pension	_____	Dividends	_____
Annuities	_____	Trust Income	_____
Rental or Real Estate	_____	Other Income	_____
Total Monthly Income	_____		

Have you sold or given away any assets or property in the past sixty (60) months? If so, please provide details including what, how much, to whom and when. (describe below)

Yes                      No

**Room**

Room applying for          Private          Semi Private          Either

**Emergency Contact Information**

**First**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship \_\_\_\_\_

**Second**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship \_\_\_\_\_

**Third**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship \_\_\_\_\_

**To Whom Should the Billing Statement be sent?**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

## GUARANTEE OF PAYMENT

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I agree to be responsible and pay for all sums due and owing Lasata Care Center upon receipt of bill. In the event that I am entitled to benefits from Medicare and Medicaid, such benefits are assigned to Lasata Care Center for application on my bill under terms as are required by the programs. In the event that I am entitled to benefits from my insurance policy, such benefits are assigned to Lasata Care Center for application on my bill. I am aware that charges for room and board, nursing care, drugs and nursing supplies, are made monthly and are for services received in the prior month. I agree to be responsible and pay for all sums not covered by these assignments.

If accepted for admission by Lasata Care Center, I agree not to make any inappropriate disposition (divestment) of assets, which would impair my ability to pay for my care.

I certify that the statements contained in this application are true to the best of my knowledge. I understand that any false statements or willful misrepresentation shall be cause for rejection of my application and may be grounds for dismissal from Lasata Care Center, if admitted.

This is an application for voluntary admission and can legally be signed by applicant or court appointed legal guardian or ACTIVATED Power of Attorney for Health Care only.

Do you wish to be on the active list or inactive list? If left blank, we will assume inactive placement.

Active

Inactive

Date

By checking this box I agree to the terms included in this form.

Save this application to your computer. Please fill out the application, and submit the completed form via email below.

Please email this form to: [kandrasic@co.ozaukee.wi.us](mailto:kandrasic@co.ozaukee.wi.us) Make sure to attach the completed application.

## DO NOT WRITE BELOW THIS LINE

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Prior to admission to Lasata Care Center you will be required to sign this application. Any information shared on this application may be shared throughout Lasata Senior Campus for the purpose of admission to other parts of the campus.

Signature \_\_\_\_\_

Date \_\_\_\_\_