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

Date Received

Admission Date

Payment Source

Doctor at Lasata

Unit Room

Resident Number

Admitted From

☐ Long Term ☐ Short Term

Personal Information

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

Medicare Number _____

Supplemental Insurance _____

Supplemental Insurance ID# _____

Long Term Care Insurance _____

Long Term Care Insurance ID # _____

Title 19 - Medical Assistance # _____

Prescription Insurance

Company Name _____

Member ID _____ RxPCN _____

RxBin _____ RxGRP _____

Medical Information

Primary Physician _____

Address _____

City _____ State ____ Zip Code _____

Phone _____

Other Physician _____

Specialty _____

Phone _____

Dentist _____

Address _____

City _____ State ____ Zip Code _____

Hospital Preference _____

Pharmacy Preference _____

Social History

Your profession or occupation before retiring

Were you in military service? ◯ Yes ◯ No

If so, which branch?

Power of Attorney

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

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 _____

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

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: mdestefano@ozaukeecounty.gov. Make sure to attach the completed application.

DO NOT WRITE BELOW THIS LINE

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 _____