Actors Fund Home
A residence of the
Entertainment Community Fund

Actors Fund Home

Dear Friends,

Thank you for your interest in the Actors Fund Home. We look forward to guiding you and your loved one through our application process and providing information about our long-term care assisted living, assisted living memory care, skilled nursing and dementia care services.

I appreciate you placing your trust in my staff and our facility, where we offer the very best care. The Home is a gold standard for senior care and a recipient of the highest rating of 5 stars from the Centers for Medicare and Medicaid Services.

In this packet, you'll find an Application as well as a Pre-Admission Checklist to help guide you through the required documentation needed. Once you've completed and signed the full application and gathered the documents listed on page one of the checklist, please submit them for review to Kathleen O'Leary via scanned email or by fax.

To streamline your application process, you can now use our interactive application found on: actorsfundhome.org.

By Email:	**By Fax:**	**By Interactive Application:**
koleary@actorsfund.org	201.589.2792 Attn: Kathleen O'Leary	**actorsfundhome.org**

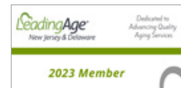
If you have any questions regarding the application, admissions process or would like to arrange a tour of the Home, please feel free to contact Kathleen O'Leary.

We look forward to hearing from you!

Warm regards,

Jordan Strohl
Executive Director
jstrohl@actorsfund.org
201.871.8882 ext. 501

Enclosures



Actors Fund Home Rate Sheet

Room and Board Rates *Effective January 1, 2025*	
Nursing Home Private Room	$690/day
Nursing Home Semi-Private Room	$600/day
Short-stay Rehabilitation—Shubert Pavilion	$752/day
Assisted Living	
—Percy Williams Wing	$391/day
—Shubert or Friedman Pavilion	$439/day
—Memory Care	$504/day
Assisted Living Community Fee	$1,000
Medicaid Application Fee	$3,000

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Actors Fund Home Pre-Admission Checklist

Applicant's Name ______________________________ Date ______________

Initial items to submit to be placed on the waiting list:

- Completed Actors Fund Home Application
- Eligibility Information: Proof of 20 years of professional experience in the performing arts or entertainment industry (resume, union pensions, playbills, articles, union earnings printout)
- Copy of Advance Directive, if applicable:
  - Living Will
  - Health Care Proxy
  - Power of Attorney
  - Guardianship papers
- Copy of birth certificate OR valid U.S. passport
- Copy of photo ID
- Verification of any name change (copy of court order)
- Copy of Medicaid documentation if applicable
- Copy of Social Security Card (front and back)
- Verification of Social Security monthly amount (award letter OR direct deposit statement)
- Copy of Medicare card (front and back)
- Copy of all secondary insurance cards (front and back)
- Copy of medical/prescription insurance cards (front and back)

(Continued on reverse)

Financial Information:

Copy of CURRENT month's financial statements (all pages of all accounts: checking, investments, savings, retirement, etc.)

Copy of most recent tax return

Copy of pension check stub showing deduction and net amount

Copy of life insurance policy

Copy of ANY documentation on Long Term Care insurance policy

Documents needed for applicants who will also need to apply for New Jersey Medicaid:

5 years of bank statements and other accounts (all pages from each month)

5 years of tax returns

Copy of Social Security award letter and/or pension check stub

Proof of marital status: marriage certificate, divorce papers or death certificate

Outstanding debt owed such as credit card, mortgage, loans, IRS, etc.

Proof of residency for the past 5 years: landlord letter, apartment lease or deed

Deed to house and/or transfer deed if land or house was transferred

Closing statement for any land or real estate sold within the past 5 years

Copy of pre-paid funeral arrangements/deed to cemetery plot

Medical documentation is NOT usually needed at the time of application. This will be requested closer to the date of admission.

If you have any questions, please contact Kathleen O'Leary by email **koleary@actorsfund.org** or call 201.871.8882 ext. 543.

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Actors Fund Home Application for Admission

Assisted Living   Memory Care Assisted Living   Nursing Home Care   Date ________

I. Applicant Information

Applicant's Name ________ Age ________

Date of Birth ________ Place of Birth (county/state) ________

Home Phone ________ Cell Phone ________

Email ________ Social Security # ________

Home Address ________

City ________ County ________ State ________ Zip Code ________

Applicant is now at

Home   Hospital   Nursing Home   Assisted Living   Other

Please identify location if not at home

Name of Facility ________

Address ________

Telephone ________ Length of Stay ________

Own Home   Rent   Other Living Arrangements

Alone or with others; please specify name, age and relationship to applicant ________

____

Primary Language   English   Other, please specify ________

Is Applicant a U.S. citizen?   Yes   No; explain citizenship status ________

Date of entry into U.S. ________

Marital Status: Married   Divorced   Single   Widowed; Date of Spouse's death ________

Name of Spouse ________

Did you serve in the Armed Forces?   No   Yes; Branch of Service ________

Religion: Jewish   Catholic   Protestant   Other, please specify ________

II. Professional Eligibility: (May be Applicant or an eligible relative)

Applicant: Professional Name

Legal Name (if different from above)

Performing Arts or Entertainment Occupation

Eligible Relative: Professional Name

Legal Name (if different from above)

Performing Arts or Entertainment Occupation

Relationship to Applicant

Union Affiliation(s) of Eligible Professional:

Union 1:

Union 2:

Union 3:

Union 4:

Please a provide brief description of Eligible Professional's career in performing arts and entertainment. (Please note you will later be asked for union printouts, IBDB printout, any other documentation):

III. Advance Directives

Does Applicant have a Financial Power of Attorney (POA)?

No
Yes; Please provide POA information below

Name of POA

Relationship

Address

City

State

Zip Code

Home Phone

Bus. Phone

Cell Phone

Email

Does Applicant have a Health Care Proxy? Yes No

Name of Proxy Relationship

Address

City State Zip Code

Home Phone Bus. Phone Cell Phone

Email

Does Applicant have Legal Guardianship? Yes No

Name of Proxy Relationship

Address

City State Zip Code

Home Phone Bus. Phone Cell Phone

Email

Other parties to be notified in case of illness, incident or emergency. (Please list in order of importance)

1. Name Relationship

Address

Cell Phone Email

2. Name Relationship

Address

Cell Phone Email

IV. Funeral Arrangements

Does Applicant have Funeral/Burial Arrangements? Yes No

Is the Burial Contract “Irrevocable?” Yes No

Name of Funeral Home/Cremation Service

Address

Telephone

V. Financial Information

Who will be responsible for managing the Applicant's finances?

Applicant: Yes No   Power of Attorney: Yes No   Other: Yes No

Will Responsible Party use Applicant's assets, as described below in Section V, to pay for Applicant's care?

Yes No

Will Applicant need to apply for New Jersey Medicaid (i.e. Applicant has less than $2,000.00 in assets)

Yes No

Current Income/Benefits (Please list ALL income here)

	Monthly Amount	Source of Income
Social Security	$	
Pension	$	
Annuity (ies)	$	
Interest	$	
Reparations	$	
Veteran's Benefits	$	
Dividends, Royalties, etc.	$	
Estates/Trusts	$	
Other	$	
TOTAL INCOME	**$**	

Assets (Please include copies of most recent statement from EACH account)

	Total Value	Name of Bank / Institution
Checking Account	$	
Savings Accounts (Money Market, Certificates of Deposit, Mutual Funds, etc.)	$	
U.S. Savings Bonds, Stocks, Securities	$	
Trust Fund	$	
IRA, Keogh or other Tax deferred income	$	
Other	$	
TOTAL ASSETS	**$**	

Liabilities (as of application date)

Please list any debts owed by the Applicant and the approximate amount (IRS, mortgage, credit card, etc.):

Does the Applicant have any pending claims, such as: lawsuits, divorce settlements, inheritance, accident claims, sale of property or other claims, or does anyone owe the Applicant money? Yes No

Please Explain

VI. Real Estate

Applicant owns real estate, situated in the Town/City of

County State

Description of property (i.e. residential, land, etc.)

Estimated market value $

Additional properties/information

VII. Insurance

Does the Applicant have Life Insurance policies with cash value? Yes No

Insurance Company Policy Number

Approximate Cash Value $

Is the Applicant named as beneficiary on another's insurance policy? Yes No

If yes, name and relationship to Applicant

Does the Applicant have Long Term Care Insurance: Yes No Insurance Company

Policy Number Name of Insured

VIII. Medical Insurance

Medicare Number ______ Does Applicant have Medicare Parts A and B? Yes No

Does Applicant have a “Medigap” or Supplemental Policy? ______

Name of Policy ______ Member I.D. Number ______

Does Applicant have a Prescription, or Part D Policy? ______

Name of Policy ______ Member I.D. Number ______

If Applicant does not have “Original Medicare”, do they have a Medicare Advantage Plan? ______

Name of Policy ______ Member I.D. Number ______

Does Applicant have a Commercial Insurance Policy, perhaps from an employer or Union? ______

Name of Policy ______ Member I.D. Number ______

IX. Miscellaneous Information

Is Applicant aware of this application and agreeable to placement? Yes No

Can Applicant be contacted regarding status of this application? Yes No

Please check the appropriate answer:

I am ready for immediate placement when a bed becomes available.
I am not ready for immediate placement when a bed becomes available.

Certification

I understand no application is considered for admission until all requested information is furnished. I agree, if admitted, to abide by the rules, regulations and policies of the Actors Fund Home. I represent that to the best of my knowledge, the above statements and information provided are true and correct.

______ Signature of Applicant/Power of Attorney ______ Signature of Representative

______ Print Name ______ Print Name

______ Date ______ Date