

The 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, as well as a perfect survey from the New Jersey State Department of Health.

In this pdf, you'll find an Application as well as a Pre-Admission Check List 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 check list, please submit them for review to Laura White via scanned email if possible, or by fax or mail:

By Email:
lwhite@actorsfund.org

By Fax:
201.266.5222
Attn: Laura White

By Mail:
Laura White, LCSW
Director of Admissions
The Actors Fund Home
155-175 West Hudson Avenue
Englewood, NJ 07631
201.871.8882 ext. 543

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 Laura White.

We look forward to hearing from you!

Warm regards,

Jordan Strohl
Administrator
jstrohl@actosfund.org
201.871.8882 ext. 501

Enclosures

The Actors Fund Home

RATE SHEET

Effective January 1, 2020

ROOM RATES

Nursing Home Private Room	\$545/day
Nursing Home Semi-Private Room	\$474/day
Short-stay Rehabilitation—Shubert Pavilion	\$595/day
Assisted Living—Percy Williams Wing	\$310/day
Assisted Living—Shubert or Friedman Pavilion	\$346/day
Assisted Living—Memory Care	\$398/day
Assisted Living Community Fee	\$1,000
Medicaid Application Fee	\$3,000

PRE-ADMISSION CHECK LIST

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 Directives:
 - Living Will
 - Health Care Proxy
 - Power of Attorney
 - Guardianship papers
- Copy of birth certificate OR valid U.S. passport
- 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: rent receipt, 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 time of application. This will be requested closer to date of admission.

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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 _____

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 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 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 3:

Union 2:

Union 4:

Please 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 Financial Power of Attorney (POA)? Yes No; Please provide POA information:

Name of POA

Relationship

Address

City

State

Zip

Home Tel.

Bus. Tel.

Cell #

Email

Does Applicant have a Health Care Proxy? Yes No

Name of Proxy Relationship

Address

City State Zip Code

Home Tel. Bus. Tel. Cell #

Email

Does Applicant have Legal Guardianship? Yes No

Name of Guardian Relationship

Address

City State Zip Code

Home Tel. Bus. Tel. Cell #

Email

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

1. Name Relationship

Address

Cell # Email

2. Name Relationship

Address

Cell # 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 Applicant and 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 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 No.

Approximate Cash Value

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

If yes, name and relationship to Applicant

Do you have Long Term Care Insurance: Yes No

Insurance Company

Policy No.

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 Plan _____ 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 he/she 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