

The Actors Fund, for everyone in entertainment.

The Lillian Booth Actors Home
155-175 West Hudson Ave., Englewood, NJ 07631
(t) 201.871.8882 (f) 201.871.9511

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Dear Prospective Resident:

Thank you for your interest in The Lillian Booth Actors Home of The Actors Fund. Enclosed you will find a brochure that includes basic information about our Assisted Living and Nursing Home Facilities. This information will give you a brief overview of The Home and the services we offer.

Also enclosed in the packet is an Admission Application and Supplemental Documentation Requirements and Check List to help guide you through the required documentation needed to process your completed application for The Home. Once all documents are attached, and your check list is complete and initialed, you may return the application packet to Rochelle Nuss, Admissions Coordinator, via fax at 212.536.7679 or by mail to:

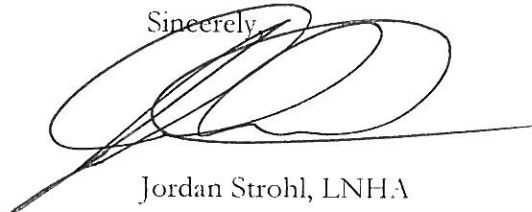
Rochelle Nuss, LSW
The Lillian Booth Actors Home
155-175 West Hudson Avenue
Englewood, NJ 07631

If you have any questions regarding the application packet, admissions process, or would like to arrange a tour of The Home, please feel free to contact Rochelle at 201.510.3422 or via e-mail at rnuss@actorsfund.org.

Come see for yourself the quality services we deliver.

Thank you again for your interest in The Home, and we look forward to hearing from you in the near future.

Sincerely,



Jordan Strohl, LNHA
Administrator
jstrohl@actorsfund.org
201.871.8882 ext. 501
201.510.3421

Enclosures

Supplemental Documentation Requirements and Check List

In order to process your application, please attach all applicable documentation listed below and initial next to each item. Thank you for your cooperation!

- _____ : Copy of Applicant's Medicare Card (Front and Back)
- _____ : Copy of Applicant's Health Insurance Cards (Front and Back) including Medicare Part D Coverage
- _____ : Copy of Applicant's Medicaid card and Approval Letter (if denied in the past, please provide a copy of Denial Letter)
- _____ : Copy of Applicant's Long Term Care Policy Insurance
- _____ : Copy of Applicant's Life Insurance Policies
- _____ : Copy of Applicant's Social Security Card
- _____ : Copy of Applicant's Social Security and/or Pension(s) Award Letter
- _____ : Copy of Applicant's Birth Certificate, Naturalization Papers, or Legal Alien Card
- _____ : Copy of Applicant's Marriage/Divorce/ Death Certificates
- _____ : Copy of Applicant's Legal Name Change
- _____ : Copy of Applicant's Burial Contract and/or Plot Information
- _____ : Copy of Applicant's Advance Directives- POA, Health Care Proxy, Living Will, Legal Guardianship
- _____ : Copy of Applicant's Deed to any properties owned
- _____ : Copy of Applicant's Tax Returns for the Last 3 Years (if no tax returns were filed, please submit a letter stating that the prospective resident has not filed taxes in the last 3 years)
- _____ : Copy of Applicant's Most Recent Bank Statements for All Accounts
- _____ : If currently or recently hospitalized, progress notes and discharge plan from the hospital (progress notes, physician's orders and medication list must be current, no less than one week old) immunization records

Applicants for The Actors Fund Homes must provide verification of a career in the entertainment industry for a minimum of twenty years. Ten out of the twenty years an individual must have industry earnings of at least \$2,000 per year. These ten years do not have to be consecutive. Verification can be provided by contacting the Union membership office and requesting a printout of earnings. Other methods of career documentation may include: W-2 forms, pay stubs and "soft documentation" such as programs and clippings. YOUR APPLICATION WILL NOT BE CONSIDERED COMPLETE WITHOUT VERIFICATION OF ELIGIBILITY.

THE LILLIAN BOOTH ACTORS HOME

APPLICATION FOR ADMISSION

Assisted Living Facility

Nursing Home Facility

1. GENERAL INFORMATION

DATE _____

Applicant's Name _____ Age _____

Date of Birth _____ Age _____ Place of Birth (county/state) _____

Social Security No. _____

Home Address _____

City _____ County _____ State _____ Zip _____

Applicant is now at: Home Hospital Nursing Home Assisted Living Other

Please identify location:

Name of Facility _____

Address _____

Telephone _____ Length of Stay _____

Own Home Rent Living Arrangements (alone or with others; please specify name, age and relationship to Applicant) _____

Primary Language: English Other, please specify _____

Is Applicant US citizen? Yes No; explain citizenship status _____

Date of entry into US _____

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:

Self: Professional Name _____

Legal Name (if different from above) _____

Entertainment Occupation _____

Eligible Relative Name _____

Entertainment Occupation _____

Relationship to applicant _____ SS# _____

Address _____

Telephone _____ Email _____

Union Affiliation(s) of Eligible Professional in Chronological Order (attach union earnings printouts if applicable):

Parent Union _____ Date _____

Others _____ Date _____

_____ Date _____

_____ Date _____

Professional Engagements of Eligible Professional in Chronological Order:

First Professional Performance/Date _____

Dates/Production	Location	Role/Position

Last Professional Performance/Date _____

III. ADVANCE DIRECTIVES:

Does Applicant have Financial Power of Attorney (POA)? No Yes (This person must sign Admissions Agreement and complete Addendum thereto)

Name of POA _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

Does Applicant have Legal Guardianship? No Yes

Name of Guardian _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

Does Applicant have a Living Will or Health Care Proxy? No Yes

Name of Proxy _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

OTHER PARTIES TO BE NOTIFIED IN CASE OF ILLNESS, INCIDENT, OR EMERGENCY IN ORDER OF IMPORTANCE:

1. Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

2. Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

3. Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Email _____

IV. FUNERAL ARRANGEMENTS

Does Applicant have Funeral/Burial Arrangements? No Yes

Is the Burial Contract "Irrevocable?" No Yes

Name of Funeral _____

Home _____

Contact Person _____ Telephone _____

Address _____

Name of Cemetery _____

Address _____

Telephone _____ Plot No. _____

Burial Account Amount _____

V. FINANCIAL INFORMATION

FINANCIAL REPRESENTATIVE/RESPONSIBLE PARTY

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Bus. Tel. _____ Cell # _____

Facsimile # _____ Email _____

Will Responsible Party use Applicant's assets, as described below in Section V, to pay for Applicant's care? No Yes

If no, identify the funds or assets to be used to pay for applicant's care _____

CURRENT INCOME/BENEFITS

	Monthly \$	Source of Income	Date
Social Security			
Pension			
Annuity (ies)			
Interest			
Reparations			

	Monthly \$	Source of Income	Date
Veteran's Benefits			
Dividends, Royalties, etc.			
Estates/Trusts			
Other			
TOTAL INCOME			

ASSETS

	Name of Bank/Institution Address & Tel. # Ownership Account No.	Total Value	Date
Checking Account			
Savings Accounts (Money Market, Certificates of Deposit, Mutual Funds, etc.)			
US Savings Bonds, Stocks, Securities			
Trust Fund			
IRA, Keogh or other Tax deferred income			
Other			
TOTAL ASSETS			

LIABILITIES (as of application date)

	Description	Amount \$	Payable to: bank, individual, etc.
Mortgages			
Credit Card debt			
Medical bills			
Outstanding bills			
Other			
Total Liabilities			

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?

No Yes Please Explain _____

Name of Attorney _____ Telephone _____

VI. REAL ESTATE

I own the following real estate, situated in the town/city of _____

County _____ State _____

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

Estimated market value _____

Property is owned by _____

Has the name(s) on the Deed to the property changed in the last 5 years? No Yes

Mortgage held by: Bank Name _____

Address _____

Type of Mortgage _____ Amount _____

I own the following real estate, situated in the town/city of _____

County _____ State _____

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

Estimated market value _____

Property is owned by _____

Has the name(s) on the Deed to the property changed in the last 5 years? No Yes

Mortgage held by: Bank Name _____

Address _____

Type of Mortgage _____ Amount _____

Additional properties/information _____

VII. INSURANCE

Does the applicant have Life Insurance Policies with cash Value? Yes No

Insurance Company _____

Policy No. _____

Approximate Cash Value _____ Annuities Amount _____

Name of Policy Holder _____

Name of Insured _____

Name of beneficiary(ies) and relationship to insured _____

Contingent beneficiary(ies) and relationship to insured _____

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

Primary Insurance Company _____

Address _____ Tel. _____

Name of Policyholder for Applicant _____

Type of coverage _____

Policy Number _____ Group _____

Secondary/Supplemental Insurance _____

Address _____ Tel. _____

Name of Policyholder for Applicant _____

Type of coverage _____

Policy Number _____ Group _____

Medicare Part D _____ Policy No. _____

Group No. _____

Has Applicant applied for New Jersey Medicaid or Public Assistance? Yes No

Date of Medicaid application _____

Caseworker Name _____

County _____ Telephone _____

Has applicant received medical and/or financial approval from Medicaid? Yes No

If yes, attach copy of Approval letter

Date Approved _____ PAS# _____ Medicaid No. _____

Was Applicant denied for Medicaid or Public Assistance? Yes No

If yes, attach copy of denial letter

Has Applicant applied for Medicaid in another state? No Yes Which State _____

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.

Please make sure to attach ALL documentation necessary on the "Supplemental Documentation Requirements and Check List" that are applicable when sending in the application packet. Please note, your application will not be considered complete and/or processed if you do not submit all required documents attached to the application. Thank you!

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 Homes. 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