

# The Actors Fund, for everyone in entertainment.

The Lillian Booth Actors Home  
155-175 W. Hudson Ave., Englewood, NJ 07631  
(T) 201.871.8882 (F) 201.871.9511

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## PRESIDENT & CEO

Joseph P. Benincasa

Dear Prospective Resident:

Thank you for your interest in The Actors Fund Home. 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 are an Admissions Application and a 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 me via email to [lwhite@actorsfund.org](mailto:lwhite@actorsfund.org), via fax at 201.266.5222 or by mail to:

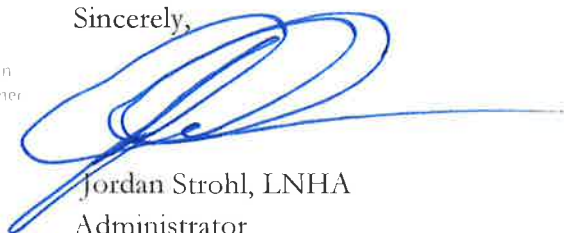
Laura P. White, LSW  
Admissions Coordinator  
The Actors Fund Home  
155-175 West Hudson Avenue  
Englewood, NJ 07631

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 Laura at 201.510.3433 or via e-mail at [lwhite@actorsfund.org](mailto:lwhite@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](mailto:jstrohl@actorsfund.org)  
201.871.8882 ext. 501  
201.510.3421

Enclosures

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# *Rate Sheet*

*Effective October 1, 2017*

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## *Room Rates*

Nursing Home Private Room	\$485/day
Nursing Home Semi-Private Room	\$421/day
Assisted Living – Main Building	\$276/day
Assisted Living – Shubert Pavilion	\$320/day
Sub-acute – Shubert Pavilion	\$550/day
Assisted Living Community Fee	\$1000
Medicaid Application Fee	\$2500

**THE ACTORS FUND HOME  
PRE-ADMISSION CHECKLIST**

**Applicant's name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Applications:**

\_\_\_\_\_ Completed Actors Fund Home Application

\_\_\_\_\_ Eligibility Information – proof of profession in the 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 US 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 on bank statement)

\_\_\_\_\_ Copy of Medicare Card (front and back)

\_\_\_\_\_ Copy of All Insurance Cards (front and back)

\_\_\_\_\_ Copy of Medical/Prescription Insurance Cards (front and back)

**Financial Information:**

\_\_\_\_\_ Copy of current 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

Continued on reverse

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

- \_\_\_\_\_ 5 years of Bank Statements and other accounts (all pages)
- \_\_\_\_\_ 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: (if coming from home)**

- \_\_\_\_\_ Doctors notes from past 3-6 months
- \_\_\_\_\_ Specialists
- \_\_\_\_\_ Medications List
- \_\_\_\_\_ Hard Copy of prescriptions from Doctor (within 30 days of move in)
- \_\_\_\_\_ Lab Tests and Results

**Medical Documentation: (if coming from Nursing Home, Rehab, Assisted Living or Hospital)**

- \_\_\_\_\_ Physician's discharge orders
- \_\_\_\_\_ Progress notes
- \_\_\_\_\_ Nurses notes
- \_\_\_\_\_ Physical Therapy and Occupational Therapy evaluation/notes
- \_\_\_\_\_ Medications List
- \_\_\_\_\_ Lab Tests and results
- \_\_\_\_\_ \*Assisted Living Only: Pre-Admission P & H form, completed and signed

THE ACTORS FUND 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**

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



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

**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			
<b>TOTAL ASSETS</b>			

**LIABILITIES (as of application date)**

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

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.

### 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