

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 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, via fax at 201.266.5222 or by mail to:

Laura P. White, LSW
Admissions Coordinator
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 Laura at 201.510.3433 or via e-mail at 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
201.871.8882 ext. 501
201.510.3421

Enclosures

**The Actors Fund,
for everyone
in entertainment.**

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155-175 West Hudson Ave., Englewood, NJ 07631
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Rate Sheet

Effective January 1, 2017

Room Rates

Nursing Home Private Room	\$485/day
Nursing Home Semi-Private Room	\$421/day
Assisted Living Room and Board Fee	\$276/day
Assisted Living Community Fee	\$1000
Medicaid Application Fee	\$2500

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

Applicant's name: _____

Date: _____

Applications:

_____ Completed Lillian Booth Actors Home Application

_____ Eligibility Information – proof of profession in the Entertainment Industry (resume, union pensions, playbills, articles, union printout from pension and health...)

_____ Copy of Advanced 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 (either award letter or dir dep on bank statement)

_____ Copy of Medicare Card (front and back)

_____ Copy of All Insurance Cards (front & 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 NJ Medicaid:

- _____ 5 years of Bank Statements and other Accounts (all pages, all accounts)
- _____ 5 years of tax returns
- _____ Copy of Social Security and/or Pension check stub- Award Letter
- _____ 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 the past 3 – 6 mos.
- _____ Specialists
- _____ Medications List
- _____ Labs/Tests and the results

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

- _____ Physicians' discharge orders
- _____ Progress notes
- _____ Nurses notes
- _____ Physical Therapy and Occupational Therapy evaluation/notes
- _____ Medications List
- _____ Hard Copy of prescriptions from Doctor (within 30 days of move in)
- _____ Labs/Tests and the results
- _____ Assisted Living Only: Pre-Admission P & H form, completed and signed

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