

Chapel Ridge

200 St. Francis Drive, Bradford, PA 16701
814-368-8499

APPLICATION FOR ADMISSION

PLEASE PRINT

I. PERSONAL INFORMATION

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____

Date of Birth: _____ Birth Place: _____

Marital Status: _____ Maiden Name: _____

Social Security Number: _____

Ethnic Background: _____

Referred by: _____

Desired Date of Occupancy: _____

Current Living Arrangements

_____ Live Alone _____ Rent _____ Own

_____ Live with Children _____ Other, please explain: _____

Are you a Pennsylvania Resident? _____ Yes _____ No

II. SPOUSE (If Applicable)

Full Name: _____

Date of Birth: _____ If Spouse is deceased, Date of Death: _____

Are you or your spouse a Veteran? _____ Yes _____ No

If yes, list branch: _____

Dates of service: _____

III. DESIGNATED PERSON (S)

Please list who you would want notified if an emergency should arise. Chapel Ridge will contact the second person of contact if your first contact is not available and so on.

1. Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____
2. Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____
3. Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____

If you have children who are not listed as Designated Persons above, please list your children's names, addresses and telephone numbers below.

Applicant's Children

1. Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____
2. Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____

3. Name: _____ Relationship: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Telephone: () _____ Work Telephone: () _____

4. Name: _____ Relationship: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Telephone: () _____ Work Telephone: () _____

*Please list additional children's names, addresses and telephone numbers on a separate sheet of paper and attach to this application.

IV. MEDICAL HISTORY AND HEALTH STATUS

Surgery and Dates: _____

Accidents: _____

Mental Health Treatment: _____ Yes _____ No
 If Yes, When _____

Allergies (Food, Medicine, Otherwise): _____

Prosthetic Devices: _____ cane _____ walker _____ manual wheel chair
 _____ motorized wheel chair _____ hearing aid (s) _____ left _____ right
 _____ dentures _____ upper _____ lower _____ eye glasses _____ pacemaker
 _____ other, please explain _____

Do you require a special diet? _____ Yes _____ No Please explain: _____

Do you require assistance getting in and out of the tub or shower? _____ Yes _____ No
 Please explain: _____

Do you bathe yourself? _____ Yes _____ No

Do you require assistance with personal grooming? _____ Yes _____ No
 Please specify: _____

Do you require assistance with dressing? _____ Yes _____ No

Do you have difficulty controlling your bowel? _____ Yes _____ No

Do you have difficulty controlling your bladder? _____ Yes _____ No

Do you smoke? _____ Yes _____ No

Do you drink alcohol? _____ Daily _____ Occasionally _____ Never

Please list current medications and/or medical treatments that you require? _____

Your Physician's Name: _____

Address: _____

Telephone: (_____) _____

Your Dentist's Name _____

Address: _____

Telephone: (_____) _____

Other Physician's Name _____

Address: _____

Telephone: (_____) _____

Current Pharmacy Name _____

Address: _____

Telephone: (_____) _____

Hospital Preference: _____

Most recent hospitalization: _____

Hospital: _____

Date: _____

Reason: _____

V. FINANCES

Social Security _____/month

Pension _____/month

Salary/Wages _____/month

Other Income _____/month

	Bank	Account#	Balance
Savings Account	_____	_____	_____
Savings Account	_____	_____	_____
Checking Account	_____	_____	_____
Checking Account	_____	_____	_____

Stocks, Bonds, Certificates of Deposit

Name	Market Value
_____	_____
_____	_____

Real Estate (Owned)

Location	Value
_____	_____
_____	_____

Other Investments and/or Assets: _____

VI. INSURANCE COVERAGE

Medicare Number: _____

Medicaid Number _____

Supplemental Insurance: _____

Group Number: _____

Monthly Premium: _____

Other Health Insurance: _____

Group Number: _____

PACE Membership Number: _____

VII. LEGAL DOCUMENTS

Do you have a durable Power of Attorney? _____ Yes _____ No

If yes, Name: _____

Address: _____

Telephone Number: (____) _____

Do you have a living will? _____ Yes _____ No

If yes, who holds a copy of your living will:

Name: _____

Address: _____

Telephone: (____) _____

Do you have a burial fund? _____ Yes _____ No

Name of Funeral Home: _____

Address: _____

Phone #: _____

VIII. PERSONAL

Religion: _____

Church: _____

Address: _____

Pastor: _____ Telephone: (____) _____

Hobbies, Interests, Organizations, and Associations

Schooling: Highest grade or degree completed: _____

Work History: Occupation(s) and Employment: _____

Do you drive? _____ Yes _____ No

If yes, do you have your own vehicle? _____ Yes _____ No

ADMISSION POLICY

It is the policy of Chapel Ridge to admit and to treat all residents without regard to race, color, national origin, ancestry, age, sex, religious creed, disability or handicap. As such, no resident shall be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service on the grounds of race, color, national origin, ancestry, age, sex, religious creed, disability or handicap.

I certify that I have read the admission policy or have had it read and explained to me and apply for admission, answering questions to the best of my knowledge, with the understanding that these conditions will apply to me as a resident of Chapel Ridge.

Applicant's Signature

Date Signed

Name and address of individual completing this application:

Name: _____ Relationship: _____

Address: _____

Return to: Administrator
Chapel Ridge
200 St. Francis Drive
Bradford, PA 16701

Date Application was received: _____

Staff person who received application: _____

Remarks: _____
