

BRADFORD ECUMENICAL HOME
100 St. Francis Drive
Bradford, Pennsylvania 16701

APPLICATION FOR ADMISSION

PERSONAL DATA DATE _____

1. Name _____
Last First Middle Maiden
2. Address _____
Street City State
 How long has he/she lived there? _____
3. Birthdate _____ Age _____ Birthplace _____
4. Marital Status: M _____ S _____ W _____ D _____ Sep _____
5. Religious Preference _____
6. Person (s) to be notified in case of emergency
 - a) Name _____ b) Name _____
 - Address _____ Address _____
 - Relation _____ Relation _____
 - Phone No. (home) _____ Phone No. (home) _____
 - (work) _____ (work) _____
8. Name of attending physician _____
9. Check all that apply:

- | | | |
|-----------------------------------|-------------------------------|---------------------------------|
| _____ increased falls | _____ ambulatory | _____ hearing impairment |
| _____ decreased appetite | _____ walks with assistance | _____ vision impairment |
| _____ mentally alert | _____ incontinent | _____ speech impairment |
| _____ memory impairment | _____ feeds self | _____ short term rehabilitation |
| _____ confused | _____ needs help with feeding | |
| _____ requires help with dressing | _____ requires special diet | |
| _____ requires help with bathing | | |

10. Is resident currently hospitalized? Yes [] No [] If yes, where? _____

FINANCIAL DATA

1. Social Security No. _____ Medicare No. _____
2. Does the resident handle his/her own financial affairs? Yes _____ No _____
 If not, who will be the responsible party?
 Name _____ Relation _____
 Address _____ Phone (home) _____
 _____ (work) _____
 Legal Status: Power of Attorney _____ Conservator _____
 Social Security Representative Payee _____
3. Does the resident pay medical insurance premiums? Yes _____ No _____
 If yes, what is the amount and how often? _____
4. Can the resident afford to pay for long term nursing home care? Yes _____ No _____
 If no, will the resident be applying for assistance for nursing home care?
 Yes _____ No _____ What county? _____

5. Monthly Income

<u>Source</u>	<u>Amount per Month</u>
Social Security	\$ _____
Private Pension	\$ _____
Veterans Benefits	\$ _____
RR Retirement	\$ _____
Dividends	\$ _____
Interest	\$ _____
SSI	\$ _____
Public Welfare	\$ _____
Other	\$ _____
 Total	 \$ _____

6. Bank Accounts/CD's

Name and Address of Bank (s)	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____

7. Real Estate

Does the resident own any property? Yes _____ No _____

If yes, please list: _____ Market Value
 \$ _____
 \$ _____

8. Health Insurance:

Blue Cross/Blue Shield: ID# _____ State _____
 Group# _____ Class _____

Other: Name _____ ID# _____
 Name _____ ID# _____

Do these policies cover nursing home care? Yes _____ No _____

9. Long Term Care Coverage:

Name of Company _____ Policy# _____

10. Medicare Part D Plan Yes _____ No _____ Name _____

11. Advance Directives? _____ DNR _____ Living Will _____ Health Care Proxy _____ Medical POA _____

12. Funeral Home _____

13. Copies of the following are required **upon admission** (No need to send with application):

- | | |
|--|---------------------|
| Social Security card | Proof of Birth Date |
| Medicare card | Power of Attorney |
| Health Insurance card (Blue Cross, Blue Shield, etc) | Living Will |
| PACE card | |
| Public Welfare card | |

Signature of Applicant

or Signature of Responsible Party

Date

If admitted, I agree to abide by the regulations of this facility. Application must be completed in full in order to be processed.