LONG TERM
APPLICATION FOR ADMISSION

COUNTY OF BUCKS
Neshaminy Manor
1660 Easton Road
Warrington, PA  18976
(215) 345-3205
APPLICATION FOR LONG TERM ADMISSION

Applicant’s Name: ________________________________

(Last)                                              (First)                               (Middle)          (Maiden)

Social Security Number: ____________________________

Reason For Application: ____________________________________________________________

Residency: Begin with present residence (home, hospital, other) and record residence(s) during past five years

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<thead>
<tr>
<th>Street</th>
<th>Town</th>
<th>County</th>
<th>Zip Code</th>
<th>From</th>
<th>To</th>
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Address: ___________________________________________________________________________

From ________To_________

Address: ___________________________________________________________________________

From ________To_________

Present Location

□ Private Home  □ Assisted Living  □ Nursing Home  □ Acute Hospital  □ Psychiatric Hospital  □ Rehabilitation Hospital

Lives Alone  □ YES  □ NO

Have you receive services from AAA Waiver Program  □ YES  □ NO

Residential history last 5 years (check all settings lived in during last 5 years)

□ Private Home  □ Assisted Living  □ Nursing Home  □ Acute Hospital  □ Psychiatric Hospital  □ Rehabilitation Hospital

Any history of mental retardation, mental illness or developmental disability  □ YES  □ NO

Date of Birth: _______  Place of Birth: _______  Age: _____  Sex: ___  Marital Status: ___  U.S. Citizen □ YES  □ NO

Primary Language: ____________________________  Other Language: ____________________________

Race/Ethnicity: □ American Indian/Alaskan Native  □ Asian/Pacific Islander  □ Black, not of Hispanic origin

□ Hispanic  □ White, not of Hispanic origin

Religion/Church Affiliation: (optional) _____________________________________________

Education – highest level completed: □ No Schooling  □ 8th grade or less  □ 9th – 11th grade  □ High School Graduate

□ Tech/Trade  □ Some College  □ Bachelor’s Degree  □ Graduate Degree

Military Service: □ YES  □ NO  War: □ WWII  □ Korean  □ Vietnam  □ Gulf War  Branch: __________

Lifetime Occupation: ______________________________

Name of Spouse: ______________________  Spouse’s SS#: ______________________  If deceased date of death: ________

Insurance:

Medicare A □  Medicare B □  Medicare #: ______________________________

Medicare Related HMO  Name ______________________________ ID # __________________________

Medicare Supplement  Name ____________________________ ID # __________________________

Medical Assistance  MA# ___________________ MA HMO Name _______________ ID # ______________

3/11/10
Do you have Long Term Care Insurance? □ YES □ NO If yes please provide a copy.

Prescription Drug Plan Name of Company ___________ ID # ________________ Subscriber’s Name ______________

Income:
Social Security: Amount _______ Disability (SSD): Amount _______ Supplemental (SSI): Amount _______
Direct Deposited □ YES □ NO

Pension:
Company Name: _______________ Address: _______________ ID #: ___________ Amount: ___________
Direct Deposited □ YES □ NO

Dividends, Interest, etc. (Source & Address) _____________________________________________________

Do You Own a Residence or Real Estate? □ YES □ NO Value: _____________________________

Has applicant transferred or given away any properties or money in the past 5 years? □ YES □ NO
If so, please explain: ___________________________________________________________________________

Bank Accounts (Checking & Savings)

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<th>Account #</th>
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CD’s, Money Market, Trust, Stocks, Bonds or IRA’s

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Life Insurance

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<th>Policy #</th>
<th>Value</th>
<th>Beneficiary</th>
<th>Loan</th>
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Responsible for Burial Arrangements: Name ___________________________________________ Phone# ____________


EMERGENCY CONTACTS:

FIRST:

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<tr>
<th>Name</th>
<th>Address</th>
<th>Zip Code</th>
<th>Relationship</th>
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I hereby certify that all the foregoing information furnished by me is TRUE and ACCURATE to the best of knowledge. I hereby acknowledge the fact that as of March 1, 1999 Neshaminy Manor is a Smoke Free facility and I hereby agree to accept and follow the facility’s established Smoking Policy.

Signature of Applicant/Responsible Party ___________________________ Date _______

Copies of all Health Insurance Cards, Medicare, Social Security Card and Advance Directives must accompany this application to ensure timeliness of admission to our facility.

3/11/10