

NESHAMINY MANOR
1660 Easton Road - Warrington, PA. 18976
(215) 345-3205

APPLICATION FOR 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
Street # Town County

Address: _____ From To

Address: _____ From To

Address: _____ From To

Address: _____ From To

Address: _____ From To

Address: _____ From To

(AB2) Present Location (check one)

- | | |
|---|--|
| 1. <input type="checkbox"/> Private Home/Apt with no Home Health Services | 5. <input type="checkbox"/> Acute Care Hospital |
| 2. <input type="checkbox"/> Private Home/Apt with Home health Services | 6. <input type="checkbox"/> Psychiatric Hospital/Mentally Retarded or
Developmentally Disabled Facility |
| 3. <input type="checkbox"/> Board & Care/Assisted Living/Group Home | 7. <input type="checkbox"/> Rehabilitation Hospital |
| 4. <input type="checkbox"/> Nursing Home | 8. <input type="checkbox"/> Other: _____ |

(AB3) Lives Alone (check one) NO YES In other facility

(AB4) Zip Code at primary residence _ _ _ _ _

(AB5) Residential history last 5 years (check all settings lived in during last 5 years)

- | | |
|---|---|
| 1. <input type="checkbox"/> Prior stay at this nursing home | 4. <input type="checkbox"/> Mental health/Psychiatric facility |
| 2. <input type="checkbox"/> Stay in another nursing home | 5. <input type="checkbox"/> Mentally Retarded/Developmentally
Disabled setting |
| 3. <input type="checkbox"/> Other residential facility, board & care
home, assisted living, group home | 6. <input type="checkbox"/> None of the above |

(AB9) Any history of mental retardation, mental illness or developmental disability YES NO

(AB10) If mentally retarded or developmentally disabled, check any conditions that were manifested before age 22, and are likely to continue indefinitely:

- | | |
|--|--------------------------------------|
| 1. <input type="checkbox"/> Downs Syndrome | 3. <input type="checkbox"/> Epilepsy |
| 2. <input type="checkbox"/> Autism | 4. <input type="checkbox"/> Other |

SECTION AC. CUSTOMARY ROUTINE

**(In year prior to admission to this nursing home, or year last in community if being admitted from another nursing home)
(Check all that apply. If all information unknown, check last box only)**

CYCLE OF DAILY EVENTS	
Stays up late at night (ex. After 9pm)	A
Naps regularly during day (at least 1 hr)	B
Goes out 1+ days a week	C
Stays busy with hobbies, reading or fixed daily routine	D
Spends most of time alone or watching TV	E
Moves independently indoors (with appliances, if used)	F
Use of tobacco products at least daily	G
None Of Above	H
EATING PATTERNS	
Distinct food preferences	I
Eats between meals all or most days	J
Use of alcoholic beverage(s) at least weekly	K
None Of Above	L

ADL PATTERNS	
In bedclothes much of day	M
Wakens to toilet all or most nights	N
Has irregular bowel movement patterns	O
Showers for bathing	P
Bathing in PM	Q
None Of Above	R
INVOLVEMENT PATTERNS	
Daily contact with relatives/close friends	S
Usually attends church, temple, synagogue (etc.)	T
Finds strength in faith	U
Daily animal companion/presence	V
Involved in group activities	W
None Of Above	X
Unknown - Resident/family unable to provide information	Y

Date of Birth: _____ **Place of Birth:** _____ **Age** _____ **Sex** _____ **Marital Status** _____

Citizen of US: _____ **Birth:** _____ **Marriage:** _____ **Alien:** _____ **Alien Number** _____

(AB8) Primary Language: _____ **Other Language(s):** _____

(AB4) Race/Ethnicity (check one):

- | | | | |
|--------------------------------|--------------------------|-------------------------------|--------------------------|
| American Indian/Alaskan Native | <input type="checkbox"/> | Hispanic | <input type="checkbox"/> |
| Asian/Pacific Islander | <input type="checkbox"/> | White, not of Hispanic origin | <input type="checkbox"/> |
| Black, not of Hispanic origin | <input type="checkbox"/> | | |

Religion/Church Affiliation: (optional) _____

(AB7) Education - highest level completed (check one):

- | | | |
|---|---|---|
| 1. <input type="checkbox"/> No schooling | 4. <input type="checkbox"/> High School Graduate | 7. <input type="checkbox"/> Bachelor's Degree |
| 2. <input type="checkbox"/> 8th grade or less | 5. <input type="checkbox"/> Technical or Trade School | 8. <input type="checkbox"/> Graduate Degree |
| 3. <input type="checkbox"/> 9th - 11th Grade | 6. <input type="checkbox"/> Some College | |

Military Service: _____ **Branch:** _____

(AB6) Lifetime Occupation: _____

Last Employer: _____
Name Address Date of Last Employment

Name of Spouse: _____

Address: _____ **Tele #:** _____

Spouse's Social Security #: _____ **If Deceased, Date of death:** _____

Father: _____ **Birthplace:** _____

Maiden Name of Mother: _____ **Birthplace:** _____

Children:

Name	Age	Address	Tele #(H)	Tele # (W)
Name	Age	Address	Tele #(H)	Tele # (W)
Name	Age	Address	Tele #(H)	Tele # (W)

Hospital Insurance*:

Medicare A Medicare B Medicare Claim # _____
 Medicare Related HMO Name _____
 Claim # _____
 Primary Physician Name & Phone # _____
 Medicare Supplement Name _____
 Claim # _____ Group # _____
 Medical Assistance MA # _____
 Medical Assistance Related HMO Name _____
 Claim # _____
 Primary Physician Name & Phone # _____
 Other (specify) _____

Income:

Social Security: Regular _____ Disability (SSD) _____ Supplemental (SSI) _____
 Direct Deposit: Yes _____ No _____ Amount Received: _____
 Pension: _____
 Name _____ Address _____ Claim # _____
 Direct Deposit: Yes _____ No _____ Amount Received: _____
 Other Benefits (specify) _____

Address	Claim #	Amount Received
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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 3 years? Yes No

If so, please explain: _____

Assets: Cash on hand: In Home, Safe Deposit Box, etc. (list)

_____ Amount _____

Back Accounts (Checking & Savings)

Bank	Name	Address	Account #	Amount
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Bank:	Name	Address	Account #	Amount
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US Government Bonds (current value): _____

Stocks and other Securities:

Name of Company	Market Value
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Life Insurance

Company	Policy #	Value	Beneficiary	Loan
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Company	Policy #	Value	Beneficiary	Loan
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Advance Directives: Family Representative, Legal Guardian, Power of Attorney, Healthcare Proxy

Name	Address	Relationship	Tele #
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Living Will, Treatment Limitations, Anatomical Gift, other directives:

Specify: _____

Responsible for Burial Arrangements: _____

Name	Tele #
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Name of Funeral Director: _____

Name	Tele #
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Cemetery: _____ **Deed #:** _____ **Lot #:** _____**EMERGENCY CONTACT(S):****FIRST:**

Name	Address	Relationship
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Tele # (H)	Tele # (W)
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SECOND:

Name	Address	Relationship
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Tele # (H)	Tele # (W)
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THIRD:

Name	Address	Relationship
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Tele # (H)	Tele # (W)
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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_____
Date_____
Signature of Informant, if other than Applicant_____
Date

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

If additional space is needed for more relevant information, please attached separate sheet.

Rev. 11/30/2001