Confidential Application For Residency

Tel Hai Retirement Community
P.O. Box 190, Honey Brook, PA 19344
Tel Hai Services (**610) 273-9333**

$250.00 Application Fee

Application for: ☐ Meadows Healthcare Center **Fax: (610) 273-4041**
☐ Lakeview Personal Care

Date: __________________

Name: ____ Telephone: ________________________

Address: ____

Date of Birth: _______________________ Age: ________ Social Security #: __________________________

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ # of Children: ____ Maiden Name: ________________

Name of Spouse (living or deceased): ________________________________ If deceased, date of death: ___________

Address (if living): ____

Billing Party: ____ Telephone: ______________________
(Responsible for Finances)

Address: ____

Power of Attorney: ____ Telephone: ______________________
(Responsible for Health Care and/or Finances – attach copy) Type: Durable ☐ Medical ☐ Financial ☐

Address: ____

<u>Names, Addresses & Telephone Numbers of Authorized Emergency Contacts</u>:

Please list designated emergency persons in order of contact preference with Medical/Durable Power of Attorney first.

1. Name: ____ Relationship: ____________________

Address: ____Go ckn<"_____________________________

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

2. Name: ____ Relationship: ____________________

Address: ____

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

3. Name: ____ Relationship: ____________________

Address: ____

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

Insurance: *(Please bring Medicare card and insurance cards to be photocopied.)*

Medicare #: ________________________________ Part A ☐ Part B ☐

Health Insurance Co.: ____________________________________ ID #: __________________ Group #: _____________

Do you have Long Term Care Insurance? Yes ☐ No ☐ What is your daily or monthly benefit? ___________

At what rate does this increase each year? _______________ How long does your policy pay for? ___________

Is this a partnership plan? Yes ☐ No ☐ Do you have a Pace/PaceNet Card? Yes ☐ No ☐

Card #: __________________________________ Medical Assistance Number *(if applicable)*:________________

Do you have Advanced Directives? (Living Will) Yes ☐ No ☐ *(Please attach copy.)*

Hospital Preference: _______________________________ Ambulance Preference: ____________________________

Religion: ________________ Church Name: _______________________________ Telephone: _________________

Funeral Director: ____ Telephone: ___________________________

Address: ____

General Information:

How do you prefer to be addressed? _________________ Past profession, trade or occupation: ________________________

Hobbies and interests:____

Do you enjoy activities? Yes ☐ No ☐ If so, which do you prefer? Group ☐ Individual ☐ Both ☐

Military Service: Yes ☐ No ☐ Branch of Service: __________________ Education level completed: ________________

Do you smoke? Yes ☐ No ☐ ***(Please note this is a non-smoking community.)*** Do you use alcohol? Yes ☐ No ☐

Have you ever resided in a: Long Term Care Residence ☐ or Assisted Living Residence ☐ ?

Name: ____

Medical Information:

Tel Hai Physician Selection (optional for Assisted Living): ____

If you have allergies (food or medications), what are they: ____

Please list any dietary restrictions or specifications: ____

Vaccines:	Dates:
Influenza	
Tetanus	
Pneumonia	

Check One:	No Change	Improved	Deteriorated
Mental Capabilities			
Ability to Care for Self			
Urinary Continence			
Behavior			
Any Weight Change			

Customary Routine: In the year prior to the date of entry into this health care center, or the year last in the community, if now being admitted from another nursing home.

*Check all that apply. If all the information is **UNKNOWN**, check last box only.*

Cycle of Daily Living

- Stays up late at night (e.g. after 9 p.m.) ☐
- Naps regularly during day (at least 1 hour) ☐
- Goes out 1+ days a week ☐
- Stays busy with hobbies, reading, or fixed daily routine ☐
- Spends most of time alone or watching TV ☐
- Moves independently indoors (with appliances, if used) ☐
- Use of tobacco products at least daily ☐
- *None of the above* ☐

Eating Patterns

- Distinct food preferences ☐
- Eats between meals all or most days ☐
- Use of alcoholic beverage(s) at least weekly ☐
- *None of the above* ☐

ADL Patterns

- In bedclothes much of day ☐
- Wakens to toilet all or most nights ☐
- Has irregular bowel movement pattern ☐
- Showers for bathing ☐
- Bathing in PM ☐
- *None of the above* ☐

Involvement Patterns

- Daily contact with relatives/close friends ☐
- Usually attends church, temple, synagogue (etc.) ☐
- Finds strength in faith ☐
- Daily animal companion/presence ☐
- Involved in group activities ☐
- *None of the above* ☐

UNKNOWN – Resident/family unable to provide information. ☐

Please include copy of Power of Attorney, Medicare Card (both sides), insurance card (both sides), Living Will or Advanced Directives, and Social Security card.

______________________ ____

Date *Signature of Applicant or Responsible Party*

____

Signature and Relationship of person completing the application.

____ __________________________

Print Name *Phone Number*

Admnp:Masterapp 9/25/09

Tel Hai Retirement Community Resident's Name:_______________________________

Does applicant have any of the following illnesses or health conditions? Please check or circle all that apply.	Yes	No
Eyes – Glaucoma/Cataracts/Macular Degeneration Sight: Good ☐ Fair ☐ Poor ☐ Blind ☐ Glasses ☐ Contacts ☐ Date of last examination: ____________________		
Ears – Wax build up Hearing: Good ☐ Fair ☐ Poor ☐ Deaf ☐ Right Aid ☐ Left Aid ☐		
Nose – Deviated Septum, Polyps, Nose Bleeds		
Throat – Dysphagia (difficulty swallowing Yes ☐ No ☐) Difficulty expressing self ☐ Speech: Good ☐ Fair ☐ Poor ☐ Difficulty understanding ☐		
Mouth – Dentures: Upper ☐ Lower ☐ Partial ☐ Full ☐ Date of last examination: ____________________		
Breasts – Cysts, Lumps/Nodules/Mastectomy		
Lungs/Breathing Problems – Tuberculosis, Bronchitis, Asthma, Pneumonia, Emphysema, Allergies, Chronic Obstructive Pulmonary Disease, Orthopnea, Shortness of Breath		
Heart – Angina, Irregular Heart Rate, Congestive Heart Failure, High Blood Pressure, Heart Attack, Stent		
Circulation – Leg Ulcers, Edema, High Blood Pressure, Varicosities, Peripheral Vascular Disease, Cerebral Insufficiency, Thrombosis, Embolism		
Extremities – Paralysis, Missing Limbs, Weakness		
Gastro-Intestinal – Ulcer, Bleeding, Colitis, Intestinal Problems, Diverticulosis, Jaundice, Gall Bladder Disease, Bowel Incontinence		
Hernia		
Genitalia – Male – Prostate Problems		
Gynecological – Post-Hysterectomy, Disease of Uterus/Cervix, Prolapse of Uterus, Ulcers of Cervix		
Musculoskeletal – Effect of Fractures, Congenital or Acquired Impairments, Osteoporosis, Osteoarthritis, Rheumatoid Arthritis, Contractures Condition of Feet: Good ☐ Fair ☐ Poor ☐		
Skin – Dry, Fragile, Rashes, Psoriasis, Open Areas, Excoriated Areas, Pressure Sores (Bed Sores), Burns, Bruises		
Nervous System – Effects of a Stroke, Parkinsonism, Cerebral Palsy, Muscular Dystrophy, Muscular Sclerosis, Polio History, Seizures, Epilepsy, Shingles		
Blood Disease – Anemia, Leukemia		
Endocrine (Glandular) Disorders – Diabetes, Thyroid, Spleen, Pancreas, Liver, Metabolic Disorders, Hepatitis		
Kidney/Urinary Tract Problems – Urinary Retention, Infection, Kidney Failure, Incontinence		
Dementia – Alzheimer's Disease, Multi-Infarct, Other		
Cancer, Tumor **Location:** ____________________		
Other Disabilities/Health Problems: (Specify): ____________________		

List of current medications being taken, dosage and frequency of administration:

Ambulation	**Yes**	**No**
Walker ____________________		
Wheelchair ____________________		
Cane ____________________		
Prosthetic Device *(artificial limbs)* ____________________		

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Applicant's Financial Statement

Tel Hai Retirement Community, P.O. Box 190, Honey Brook, PA 19344

Name: ____

Social Security # ______________________________

Medicare # ___________________________________

Medical Insurance Co. Name: ___________________

____

Insurance # __________________________________

Group # _____________________________________

List Regular Monthly Income:

Social Security Amount	$ _________________	per month
Pension	$ _________________	per month
Dividends	$ _________________	per month
Rental Income	$ _________________	per month
Mortgage Income	$ _________________	per month
Trust Income	$ _________________	per month
Other Income	$ _________________	per month
Total Income	$ _________________	per month

Capital Assets & Name of Financial Institution Holding Funds:

Cash (savings, checking, & certificates of deposit)	$ _________________	___________________________
Stocks & Bonds	$ _________________	___________________________
Home	$ _________________	___________________________
Other Real Estate	$ _________________	___________________________
Automobile	$ _________________	___________________________
Life Insurance	$ _________________	___________________________
Other Assets	$ _________________	___________________________
Total Assets	$ _________________	

List of Monthly Liabilities:

Mortgage Payment	$ _________________
Notes Payable	$ _________________
Notes Endorsed	$ _________________
Personal Debts	$ _________________
Credit Cards	$ _________________
Total Liabilities	$ _________________

Estimated Monthly Medical Expenses:

Medications	$ _________________
Medical Supplies	$ _________________
Medicare	$ _________________
Co-Insurance	$ _________________
Other	$ _________________
Total Expenses	$ _________________

Have you sold/disposed of any property in the past 5 years? Yes ☐ No ☐

If yes, Type of Property & Address: ______________________________________

Market value when sold/disposed: $ _________________

Amount sold/disposed for: $ _________________ Date of Transaction: ____________________

Have you disposed of any other assets in the past 5 years? Yes ☐ No ☐
(Example: Given away money to relatives, set up irrevocable trust accounts, etc.)

If yes, describe asset: ____

Date of Disposition: _________________

Amount Disposed: $ _________________

I do hereby certify that the information listed is true and complete to the best of my knowledge.

Signature: ____ Date: __________________