Asbury HEIGHTS

Living Well at Asbury
- Independent Living
- Personal Care
- Nursing & Rehabilitation
- Memory Support

Independent Living Application for Admission

Please answer all questions as completely and as accurately as possible. Your answers will help us to provide for all phases of your living and care here at Asbury Heights. Don't hesitate to contact us if you have any questions about this application. **All information will be held in the strictest of confidence.**

Name _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Cell phone _____

E-mail Address _____

Marital Status ☐ single ☐ divorced ☐ separated ☐ married ☐ widowed

Church/religious affiliations _____

Past occupation(s) _____

_____

_____

Date of birth _____

Birthplace _____

700 Bower Hill Road
Pittsburgh, PA 15243-2040
www.asburyheights.org
phone: 412-571-5138
fax: 412-571-5108

HEALTH INSURANCE COVERAGE

Please provide a copy of all insurance cards.

Medicare Number

Medicare Hospital Effective Date

Date issued on Medicare card

Medicare Medical Effective Date

Date issued on Medicare card

Medicaid Number

Social Security Number

Other medical insurance coverage

ID Number Group Number

Do you have prescription coverage? ☐ yes ☐ no

Prescription plan name

Claim number

Long-term health care insurance name

Please provide a copy of your long-term care policy

Are you a veteran? ☐ yes ☐ no

Are you the spouse of a veteran? ☐ yes ☐ no

Do you have any allergies? ☐ yes ☐ no

If so, please list.

CONTACT INFORMATION

Asbury HEIGHTS

Do you have a Medical Power of Attorney? ..... ☐ yes ☐ no

Name _____ Phone _____

Do you have a Financial Power of Attorney? ..... ☐ yes ☐ no

Name _____ Phone _____

Do you have a Living Will? ..... ☐ yes ☐ no

Please provide a copy of your Living Will and/or Power(s) of Attorney prior to admission.

Where would you like your monthly Asbury bills/statements sent? ..... ☐ self ☐ other

Name _____ Relationship _____

Address _____

Home phone _____ Work phone _____

Cell phone _____ E-mail address _____

Please provide your funeral home of preference.

Name _____

Address _____

City _____

State _____ Zip Code _____

Phone _____

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PRIMARY CONTACT PERSON

Name Relationship

Address

City State Zip Code

Home phone Work phone

Cell phone

E-mail address

SECONDARY CONTACT PERSON

Name Relationship

Address

City State Zip Code

Home phone Work phone

Cell phone

E-mail address

THIRD CONTACT PERSON

Name Relationship

Address

City State Zip Code

Home phone Work phone

Cell phone

E-mail address

PERSONAL HEALTH

Asbury HEIGHTS

Name _____

Date _____

Estimate the condition of your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any chronic conditions that you are treated for on an ongoing basis.

Specify any physical limitations (sight, hearing, mobility, etc.)

Describe any surgeries, illnesses or hospitalizations within the past 10 years.

Describe any mental health issues, such as anxiety or depression, including treatment and number of occurrences.

Have you fallen in the last year? ..... ☐ yes ☐ no

If so, please list the number of times and any injuries you have sustained.

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Do you get the flu vaccine annually? ☐ yes ☐ no

Have you had the Pneumovax *(pneumonia vaccine)*? ☐ yes ☐ no

If so, when?

Do you have any additional assistance in your home?
(for example, medication management, meal preparation, home help) ☐ yes ☐ no

If so, describe the services

Do you smoke? ☐ yes ☐ no

Do you drive? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no

If yes, how often?

Have you been seen by your Primary Care Physician with the last year? ☐ yes ☐ no

Name of Primary Care Physician

Address

City State Zip Code

Phone

Please list the specialists you see.

Name

Specialty Phone

Name

Specialty Phone

Please list current medications.

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PERSONAL FINANCES

(Listed assets must be available for your care, if needed.)

ASSETS	ESTIMATED VALUE	SOLE	JOINT
Real Estate			
Type	$	☐	☐
Location			
Type	$	☐	☐
Location			
Checking Account(s)			
Bank name	$	☐	☐
Bank name	$	☐	☐
Savings Account(s)			
Bank name	$	☐	☐
Bank name	$	☐	☐
Certificate(s) of Deposit			
Source	$	☐	☐
Source	$	☐	☐
Stocks, Bonds and Mutual Funds			
Description	$	☐	☐
Number of shares/bonds			
Description	$	☐	☐
Number of shares/bonds			
Description	$	☐	☐
Number of shares/bonds			
Trust Fund			
Bank	$	☐	☐
Trust officer name and phone			
Date established (month/day/year)			
Is this trust irrevocable? ☐ yes ☐ no			
Do you have life insurance? ☐ yes ☐ no			
Estimate cash value	$		

LIABILITIES	AMOUNT	SOLE	JOINT
Lender	$	☐	☐

INCOME

	PER MONTH
Social Security	$
Wage earner, if not self	
Pension	$
Type	
Through whom, if not self	
Veterans Administration Compensation	$
☐ yes ☐ no claim number	
Other Income	$
	$
	$

I authorize Asbury Heights to verify this information with the financial institutions listed, or any other appropriate agency.

The undersigned applies for admission to Asbury Heights with the understanding that the information contained in this application is true and correct and that incorrect information entitles Asbury Heights, at its option, to cancel any Agreements entered into with the Applicant and/or Responsible Party.

Signature of applicant or responsible party Date

Name, address and phone number of
person completing application, if not applicant.

Asbury Heights complies with the provisions of the Federal Civil Rights Act of 1964 and the Pennsylvania Human Relations Act to the end that no person shall, on the ground of race, color, national origin, ancestry, age, disability, or sex be excluded from participation in or the benefit of any service or care.