Asbury HEIGHTS

Part of UPMC Senior Communities

Independent Living Application for Admission

- Independent Living
- Personal Care
- Nursing & Rehabilitation
- Memory Support

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

Which branch of service?

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

Which branch of service?

Do you have any allergies? ☐ yes ☐ no

If so, please list.

CONTACT INFORMATION

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

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 _____

TERTIARY CONTACT PERSON

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

E-mail Address _____

PERSONAL HEALTH

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.

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 within the last year? ☐ yes ☐ no

Name of Primary Care Physician

Address

City State Zip Code

Phone

Please list the Medical Specialists you see.

Name

Specialty Phone

Name

Specialty Phone

Please list current medications.

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)		**YES**	**NO**
Is this trust irrevocable?		☐	☐
Do you have life insurance?		☐	☐
Estimated cash value	$		

LIABILITIES	AMOUNT	SOLE	JOINT
Lender	$	☐	☐

INCOME	PER MONTH
Social Security	$
Wage earner, if not self	
Pension	$
Type	
Through whom, if not self	
	YES / NO
Veterans Administration Compensation	$ ☐ ☐
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[1], part of UPMC Senior Communities, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

[1]Asbury Heights is the marketing name used to refer to the following companies: Asbury Foundation, Asbury Villas, Asbury Place, Wesley Hills, and The Embassy of Asbury Heights.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-293-8133.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-293-8133.