Asbury HEIGHTS

Part of UPMC Senior Communities

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

Personal Care 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

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

700 Bower Hill Road
Pittsburgh, PA 15243-2040
www.asburyheights.org

- Personal Care and Memory Support
  phone: 412-571-5387
  fax: 412-571-5108

Social Security Number

Other medical insurance coverage

ID Number Group Number

Do you have prescription coverage? ☐ yes ☐ no

Prescription plan name

Claim number

Pharmacy of choice

Long-term health care insurance name

Please provide a copy of your long-term care policy

Are you a veteran? ☐ yes ☐ no What branch of service?

Are you the spouse of a veteran? ☐ yes ☐ no What branch of service?

Do you have any allergies? ☐ yes ☐ no

If so, please list.

PERSONAL HEALTH

What is the name and phone number of your Primary Care Physician?

Name Phone

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

Please list the Medical Specialists you see.

Name

Specialty Phone

Name

Specialty Phone

Name

Specialty Phone

Please list current medications.

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.)

Has your loved one fallen within the last year? ☐ yes ☐ no

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.

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

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

If so, when?

Have you had a geriatric assessment? ☐ yes ☐ no

If so, when and where?

Do you require assistance with your medication? ☐ yes ☐ no

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Do you wear a hearing aid? ☐ yes ☐ no
If so, ☐ left ear ☐ right ear

Is your vision normal? ☐ yes ☐ no
If not, ☐ glasses ☐ contacts ☐ blind

Do you wear dentures? ☐ yes ☐ no
If so, ☐ upper ☐ lower ☐ partial

Is your speech normal? ☐ yes ☐ no
☐ impaired ☐ non-English

(please specify) _____

Have you had recent weight loss? ☐ yes ☐ no

Do you have swallowing problems? ☐ yes ☐ no

How is your appetite? ☐ good ☐ fair ☐ poor

Do you need help eating? ☐ yes ☐ no

Do you need a special diet? ☐ yes ☐ no

(please specify) _____

Mental Status: ☐ alert ☐ confused ☐ noisy ☐ converses with others
☐ socializes with others ☐ wanders ☐ forgetful ☐ combative

Please describe behaviors and moods that occur as a result of forgetfulness and confusion (be specific).

_____

_____

Is your loved one able to make his/her needs known? ☐ yes ☐ no

Does your loved one have any memory loss? ☐ yes ☐ no

If yes, how is his/her recall? Can he/she remember details from
a few minutes ago? ☐ yes ☐ no
a few hours ago? ☐ yes ☐ no
yesterday? ☐ yes ☐ no

Do they show self-initiation with the following:
getting out of bed? ☐ yes ☐ no
eating/preparing meals? ☐ yes ☐ no
moving from one place to another ☐ yes ☐ no
engaging in social situations/activities ☐ yes ☐ no

If there was an emergency in their home would they
know what to do/how to respond appropriately? ☐ yes ☐ no

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.

Do you have a Physician's Order for Life Sustaining Treatment? ☐ yes ☐ no

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

Name Relationship

Address

City State Zip Code

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

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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	
Railroad retirement	$
Wage earner, 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.