

Personal Care 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 _____

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 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Location _____			
Type _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Location _____			
Checking Account(s)			
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Savings Account(s)			
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Certificate(s) of Deposit			
Source _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Source _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Stocks, Bonds and Mutual Funds			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Trust Fund			
Bank _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Trust officer name and phone _____			
Date established (month/day/year) _____			
Is this trust irrevocable? <input type="checkbox"/> yes <input type="checkbox"/> no			
Do you have life insurance? <input type="checkbox"/> yes <input type="checkbox"/> no			
Estimate cash value _____	\$ _____		

LIABILITIES	AMOUNT	SOLE	JOINT
Lender	\$	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			

INCOME	PER MONTH
Social Security	\$
<hr/>	
Wage earner, if not self	
<hr/>	
Pension	\$
<hr/>	
Type	
<hr/>	
Through whom, if not self	
<hr/>	
Railroad retirement	\$
<hr/>	
Wage earner, if not self	
<hr/>	
Veterans Administration Compensation	\$
<hr/>	
<input type="checkbox"/> yes <input type="checkbox"/> no claim number	
<hr/>	
Other Income	\$
<hr/>	
	\$
<hr/>	
	\$
<hr/>	

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