

LEBANON VALLEY BRETHREN HOME
 1200 GRUBB ROAD · PALMYRA PA 17078

APPLICANT NAME: _____



APPLICATION FOR ADMISSION

DATE _____ REFERRED BY _____

APPLICATION FOR: PERSONAL CARE
 NURSING CARE.....
 DEMENTIA UNIT.....

NAME OF APPLICANT _____
FIRST MIDDLE LAST (MAIDEN)

PRESENT ADDRESS _____
STREET / ROUTE TOWN / CITY STATE ZIP CODE

TELEPHONE NUMBER (____) _____ U.S. CITIZEN? YES NO If NO, WHERE? _____

SOCIAL SECURITY # ____ - ____ - ____ MEDICARE # _____ MEDICAID # (IF APPLICABLE) _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

A. FULL NAME OF SPOUSE _____

B. AGE OF SPOUSE _____ C. DATE OF DEATH (IF WIDOWED) _____

VETERAN OF MILITARY SERVICE? YES NO

COMPLETE BELOW:

CHILDREN, BROTHERS, SISTERS OR CONTACT PERSON, INDICATING POWER OF ATTORNEY

<u>NAME</u>	<u>ADDRESS</u>	<u>RELATIONSHIP</u>	<u>HOME/WORK/CELL PHONE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

APPLICANT NAME: _____

RELIGIOUS AFFILIATION: PROTESTANT CATHOLIC JEWISH N/A OTHER _____

NAME OF CHURCH: _____ ADDRESS: _____

NAME OF PASTOR: _____ TELEPHONE NUMBER: (_____) _____

EDUCATIONAL BACKGROUND:

HIGHEST GRADE COMPLETED _____ OTHER SPECIALIZED TRAINING _____

EMPLOYMENT BACKGROUND:

OCCUPATION(S) _____ EMPLOYER(S) _____

NAME, ADDRESS AND TELEPHONE NUMBER OF PRIMARY PHYSICIAN:

NAME _____ PHONE NUMBER _____

STREET _____ CITY, STATE, ZIP CODE _____

DATE OF LAST PHYSICAL EXAM _____ HOSPITAL PREFERENCE _____

CURRENT MEDICAL PROBLEMS/DIAGNOSIS:

CURRENT MEDICATIONS BEING TAKEN:

FUNERAL ARRANGEMENTS:

A. FUNERAL HOME PREFERRED _____ FUNERAL PRE-PAID? YES NO

ADDRESS _____ TELEPHONE (_____) _____

B. SPECIFIC WRITTEN INSTRUCTIONS FOR AUTOPSY, DONATION OF ANY BODY PARTS, CREMATION, ETC.

YES NO IF YES, WHO HAS THESE INSTRUCTIONS _____

C. NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON RESPONSIBLE FOR ARRANGEMENTS:

NAME(S) _____ TELEPHONE (_____) _____

ADDRESS _____ CITY, STATE, ZIP _____

PAST/PRESENT LIVING SITUATION: LIVING ALONE WITH SPOUSE OTHER (NAME/RELATION) _____

HAVE YOU BEEN A RESIDENT IN ANY OTHER HOME/FACILITY/INSTITUTION? YES NO

IF YES, FROM _____ TO _____ NAME/ADDRESS OF FACILITY _____

APPLICANT SIGNATURE: _____ POWER OF ATTORNEY: _____

DATE: _____



FINANCIAL STATEMENT

THIS FINANCIAL STATEMENT IS PART OF THE APPLICATION PROCESS AND MUST BE COMPLETED.
 INFORMATION WILL BE KEPT CONFIDENTIAL.

ASSETS

MONEY IN BANK OR ELSEWHERE (SAVINGS, CHECKING, CD'S TRUSTS, ANNUITIES, ETC...) PLEASE INDICATE IF JOINT ACCOUNT:

TYPE OF ACCOUNT:	CURRENT BALANCE (\$):	NAME OF FINANCIAL INSTITUTION:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INVESTMENTS: CURRENT VALUE OF STOCKS, BONDS, ETC. \$ _____
 CURRENT VALUE OF ANY RETIREMENT FUNDS (E.G., 401K) \$ _____

LIFE INSURANCE: (ATTACH ADDITIONAL INSURANCE INFORMATION IF NECESSARY)

<u>COMPANY</u>	<u>POLICY No.</u>	<u>OWNER</u>	<u>BENEFICIARY</u>	<u>CASH VALUE</u>	<u>FACE VALUE</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

REAL ESTATE:

HOUSE(S) AND LOT(S) _____ LOCATION _____ MARKET VALUE \$ _____
 FARM(S) _____ ACREAGE _____ LOCATION _____ MARKET VALUE \$ _____
 LIFE ESTATE IN ANY PROPERTY _____ VALUE \$ _____

SOURCES OF INCOME

MONTHLY AMOUNT RECEIVED FOR:

SOCIAL SECURITY \$ _____ MEDICAID \$ _____ ANNUITIES \$ _____
 SSI \$ _____ PENSION \$ _____ OTHER \$ _____

DO YOU HAVE:

PRIMARY HEALTH INSURANCE: _____
 SUPPLEMENTAL INSURANCE: _____
 LONG TERM CARE INSURANCE: _____

APPLICANT NAME: _____

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OTHER INFORMATION

BURIAL FUND, IF YES, WHERE DEPOSITED _____
AMOUNT \$ _____

ANY ASSETS TRANSFERRED TO FAMILY OR AN ORGANIZATION IN THE LAST 5 YEARS? YES NO
IF YES, TO WHOM TRANSFERRED _____
WHEN _____ AMOUNT \$ _____

FINANCIAL POWER OF ATTORNEY _____ PHONE _____

HEALTH CARE POWER OF ATTORNEY _____ PHONE _____

NOTE: PLEASE ATTACH COPY OF DOCUMENT(S)

HAS A LIVING WILL / ADVANCE DIRECTIVE BEEN EXECUTED? YES NO
IF YES, PLEASE ATTACH COPY OF DOCUMENT(S)

PERSON RESPONSIBLE FOR PAYMENT OF BILLS:

NAME: _____ STREET OR ROUTE _____

PHONE NUMBER: (_____) _____ CITY, STATE, ZIP _____

APPLICANT'S SIGNATURE / POA SIGNATURE: _____ DATE: _____

ADDITIONAL INFORMATION:
