



# LEBANON VALLEY BRETHERN HOME

1200 GRUBB ROAD · PALMYRA, PA 17078

## WAIT LIST APPLICATION RESIDENTIAL LIVING

Date \_\_\_\_\_ Type of Unit you prefer \_\_\_\_\_

NAME OF APPLICANT \_\_\_\_\_  
FIRST MIDDLE LAST (MAIDEN)

PRESENT ADDRESS \_\_\_\_\_  
STREET or ROUTE TOWN or CITY STATE ZIP CODE

TELEPHONE NUMBER \_\_\_\_\_ U.S. CITIZEN?  YES  IF NO, WHERE? \_\_\_\_\_  
AREA CODE

SOCIAL SECURITY NO. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MEDICARE NUMBER \_\_\_\_\_ ARMED SERVICES VETERAN ? \_\_\_\_YES \_\_\_\_NO

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  
MONTH / DAY / YEAR TOWN or CITY STATE

MARITAL STATUS:  SINGLE  MARRIED (a & b)  WIDOWED (a,b,c)  DIVORCED

a. Full Name of Spouse \_\_\_\_\_

b. Age of Spouse \_\_\_\_\_ c. Date of Death (if widowed) \_\_\_\_\_

### NAMES AND ADDRESSES OF EMERGENCY CONTACT PERSONS:

NAME	ADDRESS	RELATIONSHIP	HOME / BUSINESS TELEPHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### HEALTH CARE POWER-OF-ATTORNEY:

\_\_\_\_\_

### FINANCIAL POWER-OF-ATTORNEY:

\_\_\_\_\_

### HOW DID YOU HEAR ABOUT LEBANON VALLEY BRETHERN HOME?

\_\_\_\_\_



# MEDICAL INFORMATION

RESIDENT'S NAME-----

NAME, ADDRESS, AND TELEPHONE NUMBER OF PRIMARY PHYSICIAN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
STREET or ROUTE                      TOWN or CITY                      STATE                      ZIP CODE  
\_\_\_\_\_  
AREA CODE                      TELEPHONE NUMBER                      DATE OF YOUR LAST MEDICAL EXAMINATION \_\_\_\_\_

[INFORMATION BELOW TO BE COMPLETED BY APPLICANT'S PERSONAL PHYSICIAN]

HOW LONG HAVE YOU KNOWN THE APPLICANT? \_\_\_\_\_

IN YOUR OPINION, IS APPLICANT CAPABLE OF LIVING INDEPENDENTLY? \_\_\_ YES \_\_\_ NO

IN THE EVENT OF A FIRE, COULD APPLICANT EVACUATE HOME BY THEMSELVES? \_\_\_ YES \_\_\_ NO

HEIGHT \_\_\_\_\_                      WEIGHT \_\_\_\_\_                      B/P \_\_\_\_\_                      PULSE \_\_\_\_\_

CURRENT DIAGNOSES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HISTORY OF PAST SURGERIES OR MAJOR ILLNESSES:

CAN APPLICANT SELF-MANAGE HIS/HER MEDICATIONS? \_\_\_ YES \_\_\_ NO

ANY HISTORY OF:

ALCOHOL ABUSE                      \_\_\_ YES \_\_\_ NO                      TOBACCO USE                      \_\_\_ YES \_\_\_ NO  
PSYCHIATRIC ILLNESS                      \_\_\_ YES \_\_\_ NO                      S/S OF DEMENTIA                      \_\_\_ YES \_\_\_ NO

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

