



ADMISSION APPLICATION FOR NURSING CARE: GENERAL USE

Return completed application to: ADMISSIONS phone 717.866.3504 fax 717.866.3291

COMMUNITY PREFERENCE (*Contingent upon bed availability*):

- TOWNE CENTRE at 7 West Park Avenue, Myerstown, PA 17067 phone 717.866.6541
- POPLAR RUN at 450 East Lincoln Avenue, Myerstown, PA 17067 phone 717.866.3200
- NO PREFERENCE/FIRST AVAILABLE BED

StoneRidge will attempt to accommodate community preference as able. If admission is made to the non-preferred community, we will attempt to transfer resident to the preferred community when a bed is available and it will not adversely affect the resident.

ITEMS REQUIRED WITH APPLICATION

The following items (*If applicable*) are required to accompany this application if admission to StoneRidge is to be considered:

- 1) Most recent 3 months bank statements from every bank account
- 2) Proof of other assets (*Individual retirement accounts, stocks, bonds, brokerage accounts, property, etc*)
- 3) Proof of monthly income (*If direct deposit, this will be on the bank statements*)
- 4) Copy of Power of Attorney
- 5) Copy of insurance cards (*Both front & back*)

SECTION 1: GENERAL INFORMATION

Name _____ Social Security Number _____

Date of Birth _____ Male Female

Address _____



Telephone _____ Email _____

Marital Status: Single Married Divorced Widowed

Applicant's current location _____

Reason for Placement _____

PRIMARY CONTACT

Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Applicant _____

Living Will? Yes No (*If yes, please provide copy*)

If no Living Will is provided, the admitted Resident will be considered *Do Not Resuscitate* as per the policy of StoneRidge Retirement Living.

Medical Power of Attorney? (POA) Yes No (*If yes, provide copy*)

FINANCIAL POA OR RESPONSIBLE PARTY

Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Does above person/bank currently manage your finances? Yes No

Religious Denomination _____

Name of Church/Synagogue _____

Clergyman/Rabbi _____ Phone _____

Funeral Home _____ Phone _____



Address _____

What is your former occupation? _____

What are your hobbies/interests? _____

EMERGENCY CONTACTS *(After primary contact person)*

#2 Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Applicant _____

#3 Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Applicant _____

MEDICAL HEALTH INSURANCE *(Please provide copies of all insurance cards, including prescription coverage, front and back)*

Medicare Insurance Holder _____

Plan _____ Effective Date _____

Medicare ID Number _____

Supplemental Insurance _____

ID Number _____ Group Number _____

Name of Insurance Holder _____



SECTION II: PERSONAL HEALTH QUESTIONNAIRE

1. Primary Physician Name _____

Address _____

Work Phone _____

2. List other physicians who have treated you within the past 24 months:

Name	Specialty	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List any hospitalizations within the past 12 months:

Where	Condition	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Hospital Preference: _____

5. List all medications currently being taken (*Including over the counter medications*):

6. Describe any allergies (*i.e foods, medications, etc.*):

7. Date of most recent: Flu Shot _____ Pneumovax _____



8. Are you currently receiving?

Physical Therapy _____ Where _____ Condition _____

Speech Therapy _____ Where _____ Condition _____

Occupational Therapy _____ Where _____ Condition _____

9. Specify any physical limitations: _____

10. Please check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alzheimer's Dx | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Huntingtons's Dx | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tight Chest |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Parkinson's Dx | <input type="checkbox"/> Weight Loss/Gain |

If you checked any of the previous, please explain: _____

11. Mental Status Information:

Is the applicant alert and cooperative? Yes No

Is the applicant noisy and combative? Yes No



Does the applicant have episodes of

violent outbursts of temper?

Yes No

Does the applicant tend to be

depressed and withdrawn?

Yes No

Does the applicant manifest any

signs of unusual behavior?

Yes No

Has the applicant ever been under

a physician's care for mental illness?

Yes No

If you checked yes to any of the above, please explain:

12. Has the applicant been admitted to a psychiatric institution within the past 24 months? Yes No

If yes, explain circumstances _____

13. Please check any current or recent condition:

Sight Normal Abnormal

Explain _____

Speech Normal Abnormal

Explain _____

Hearing Normal Abnormal

Explain _____



- Mobility Walks Unassisted Walks Assisted Walks with device*
- Eating Habits Regular Diet Special Diet* Feeding Tube
- Bladder Habits Voluntary Ileostomy Involuntary*
- Colostomy Catheter

Please give an explanation if you checked any of the above with an "*":

SECTION III: FINANCIAL INFORMATION

1. Do you have a life insurance policy in effect? Yes No

If yes, please complete the following:

Policy Holder	Beneficiary	Type	Amount of Coverage	Cash Surrender Value
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2. Are you named the beneficiary of a life insurance policy or will? Yes No

If yes, please complete the following:

Policy	Amount of Coverage	Will
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SOURCES OF INCOME

Amount Received Per Month

1. Social Security _____

2. Pension/Annuity _____

3. Interest & Dividends _____

4. Other Income _____

Description _____

5. Total Income _____

Is there an expiration date on any of the above? Yes No

Please Explain _____

ASSETS

1. Cash-Checking \$ _____

2. Cash-Savings \$ _____

Institution	Type of Account	Maturity Date	Amount
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3. Real Estate Owned (*Please describe*)

4. Have you sold or disposed of any real estate in the last five years? Yes No

If yes, please list value of said real estate _____



5. Stocks, Bonds and Investments *(Please describe. Include any items owned within the last five years)*

6. Other Assets *(Owned within the last five years)*

7. **Total Assets** *(Sum of items 1-6)* _____

(Please include copies of the past two years income tax returns, latest statements of stocks, IRA's, annuities, mutual funds, bonds and any other types of investments, along with the most recent bank statement.)

LIABILITIES

8. Mortgages on real estate _____

9. Notes Payable _____

10. Other Liabilities _____

Description _____ Amount _____

11. **Total Liabilities** *(Sum of items 8-10)* _____

12. **Net Worth** *(Line 7 less line 11)* _____

If this statement was prepared by a person other than the person seeking admission, please state:

Name _____

Address _____

Phone _____



AUTHORIZATION

Everything stated in this application is true and correct. I understand that any misrepresentation of facts will result in termination of residency at the StoneRidge Retirement Living. I also understand that StoneRidge Retirement Living considers this application as a continuing statement of financial and medical condition and agree to notify StoneRidge Retirement Living in writing of any substantial change in the aforementioned financial and medical condition. All of this information will be kept strictly confidential by the StoneRidge Retirement Living. I agree that a photocopy shall have the full force and effect as the original of this application.

A \$300 admission fee is charged to everyone admitted to StoneRidge. This is a once in a lifetime fee which is not covered by insurances. This fee will be billed once the person has established admission at either StoneRidge community.

StoneRidge Retirement Living nursing units are smoke/tobacco free environments. There is no smoking or tobacco use permitted at either the Albright or StoneRidge nursing unit or on the nursing unit grounds. As of January 1, 2009, the entire properties of StoneRidge Retirement Living will be tobacco/smoke free for both residents and staff. There will be no smoking or tobacco use permitted by residents or staff of either the Towne Centre or Poplar Run Communities at all levels of care.

Signature of Applicant _____ Date _____

Relationship if not Applicant _____

Return completed application to:

ADMISSIONS

StoneRidge Retirement Living

450 East Lincoln Avenue, Myerstown, PA 17067

phone 717.866.3504 fax 717.866.3291