**COLONIAL WOODS**

**Personal Care Home**

**1710 Creek Rd, Glenmoore, Pa 19341**

**Phone (610)942-4242 Fax (610)942-2039 Email** [**info@colonialwoodspersonalcare.com**](mailto:info@colonialwoodspersonalcare.com)

**Application for Admission**

GENERAL INFORMATION

Applicant’s Name Sex: F M

Home Address

City County State Zip Code

Birth Date Birth Place Religion

U.S. Citizen: Yes No If no, explain citizenship status, give date of entry into the U.S.:

Social security No.

Applicant is now at; Home Hospital Nursing Home Other

Please identify locations: Name

Contact information

How long has the Applicant been at this location?

Primary Language; English other (please Specify)

Marital Status; Single Married Divorced Widow(er)

Spouse’s Name

Is he or she living? Yes or No Are you a spouse of a veteran? Yes No if yes, please provide: Branch of service Date of service

Type of accommodations you are applying in for: Private Room Semi-Private room

**PERSONAL CONTACT**

Does the Applicant have any of the following? If yes, complete the contact information below.

Medical Power of attorney Financial Power of attorney Legal Guardian

Name Phone No.

Address

Please identify a family member, guardian, POA, responsible person and/or designated community agency to be notified in case of illness, incident or other emergency:

1. Name Relationship

Address

City State Zip Code

Phone No. Home Cell

1. Name Relationship

Address

City State Zip Code

Phone No. Home Cell

1. Name Relationship

Address

City State Zip Code

Phone No. Home Cell

Financial Sponsor/ Representative (Party responsible for making payment) Self? Yes No List other below.

Name Relationship

Address

City State Zip Code

Phone No. Home Cell

Is this person/agency the Applicant’s Representative Payee?

Funeral/ Burial Arrangements

Name of Funeral Home Phone No

Address

Name of Cemetery Phone No

Address

Does the Applicant have any condition that requires special care and attention? Yes No if Yes, Describe:

Does the Applicant have a living will/Advance directive, DNR? Yes No (If yes attach copies)

**APPLICANT’S MENTAL STATUS**

Is the Applicant alert? Yes No Confused? Yes No Depressed or Withdrawn? Yes No

Does the Applicant wander? Yes No Does the Applicant have outbursts of temper? Yes No

Does the Applicant have episode of crying, yelling, or screaming? Yes No

Does the Applicant generally get along well with others? Yes No Suicidal thoughts? Yes No

Does the Applicant pose a danger to self or others? Yes No

State any other significant event or occurrence about the Applicant’s mental condition (or anything else the Home should know about the applicant’s mental condition):

**APPLICANT’S CARE NEEDS**

Grooms self: Yes No Bathes Self: Yes No Dresses self: Yes No

Feeds self: Yes No

Physical Mobility: Walks unassisted: Yes No Needs assistance: Yes No

Uses cane: Yes No Propels own wheeler chair: Yes No Bed bound: Yes No

Is the Applicant Continent? Yes No Bladder: Yes No Bowel: Yes No Both: Yes No

Use incontinency products? Yes No Needs no assistance: Yes No Requires assistance: Yes No

Need assistance with toileting? Yes No Receiving wound care? Yes No Bed Sores? Yes No

Does the Applicant need catheter? Yes No Oxygen? Yes No Feeding tube? Yes No

Special diet instruction:

Does the applicant have a communicable disease, which could be transmitted to other residents or staff? Yes No

If yes, Describe

**List the Applicants’ current physicians**

1. Name Type of physician

Contact information

1. Name Type of physician

Contact information

1. Name Type of physician

Contact information

1. Name Type of physician

Contact information

Does Applicant smoke? Yes No if a smoker is accepted they must follow the home’s rules and be able to get to smoking location (front porch) without staff assistance.

Does the applicant intend to bring a car: Yes No if Yes, describe (Year, Make, Model)

Current registration? Yes No

**HEALTH INSURANCE**

Medicare No Part A Part B Medicare part D No

Prescription Card No

Access No County

Other Medical Insurance: Name

Identification No Group No

**APPLICANT’S FINANCIAL INFORMATION**

**Please attach proof of income &most recent account statements for items listed below.**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. CURRENT INCOME/BENEFITS | Monthly | Annually | Company/ source  Name, Address, phone |
| Supplemental Security Income (SSI) |  |  |  |
| Social Security |  |  |  |
| Public Assistance |  |  |  |
| Retirement Plan |  |  |  |
| IRA, Keogh or other tax deferred income |  |  |  |
| Veterans Benefit |  |  |  |
| Fed Civil Service Annuity |  |  |  |
| Unemployment Compensation |  |  |  |
| Sick or Disability payments |  |  |  |
| Annuities, Dividends, Interest |  |  |  |
| Estates, Trusts |  |  |  |
| Child support, Alimony, inheritance |  |  |  |
| other |  |  |  |
| **TOTAL INCOME** |  |  |  |

1. **ASSETS**

|  |  |
| --- | --- |
| Name of Bank/institution /person address &phone no. account or certificate no. ownership (joint, self) | Total Value |
| Cash on hand |  |
| Checking account |  |
| Saving account including: |  |
| Money market, funds, savings certificates, Christmas club, vacation club |  |
| Stocks & Bonds |  |
| Trust funds |  |
| Tangible personal Property |  |
| Vehicles |  |
| Real Estates |  |
| Other |  |
| **TOTAL ASSETS** |  |
|  |  |

1. **INSURANCE**
2. Life Insurance

Insurance Company Name

Policy No. Policy Holder

Face Value Cash Value

Beneficiary Relationship to insured

1. Long Term Care Insurance

Insurance Company name

Policy No. Name of Insured

1. **LIABILITIES AS OF DATE OF APPLICATION**

|  |  |  |
| --- | --- | --- |
| Description | Amount | Payable to Whom |
| Notes |  |  |
| Loans |  |  |
| Credit Cards |  |  |
| Rent /Mortgages |  |  |
| Life Insurance |  |  |
| Utilities |  |  |
| Child Support/Alimony |  |  |
| Social Security Overpayment |  |  |
| Unpaid Fed Tax |  |  |
| Other |  |  |
| **TOTAL LIABILITY COSTS** |  |  |
|  |  |  |

Is the Applicant aware of this application and agreeable to placement? Yes No

**I/We have fully disclosed to Colonial Woods PCH and have provided documentation of my entire monthly income, assets and trust information. I/We understand that anything less than full disclosure of all income, asset and trust information is considered fraud and will lead to costs passed on the resident for this misrepresentation and possible discharge from Colonial Woods PCH.**

**If applicable, I/We understand that if I/We sell any real estate after moving into the facility, it would become capital gain and I would be required to disclose this information to the facility. Capital gain could affect government subsidy status with this facility**

**I understand that Colonial Woods PCH is not a medical facility and does not have medical professionals on staff. I agree to utilize and follow the emergency procedure put in place.**

**I understand no application is considered for admission until all requested information is furnished. I agree, if admitted, to abide by the rules, regulations and policies of Colonial Woods PCH.**

**I represent that to the best of my knowledge the above statements and information are true and correct.**

**Signature of Applicant Date**

**Print Name**

**Signature of POA, Guardian Date**

**Witness Date**