

ADMISSION APPLICATION

Valley View Retirement Community
 4702 East Main Street
 Belleville, PA 17004
 PH: (717) 935-2105 • Fax: (717) 935-5109

Malta Home Retirement Community
 105 Malta Drive
 Granville, PA 17029
 PH: (717) 248-3988 • Fax: (717) 248-2780

APPLICATION FOR ADMISSION TO:

Valley View Haven (Nursing Care) _____ | Malta Home (Nursing Care) _____
 Valley View Terrace (Supportive Care) _____

Would accept admission to either Facility for: Nursing Care _____

The information asked for on this form is needed to evaluate the applicant's request for admission. All information will be considered by the Admissions Committee and will be held in strict confidence. The acceptance of this form does not bind either party to admission. Failure to complete the application in its entirety could result in denial of consideration for admission. When two individuals apply together, a separate application must be completed for each one.

Valley View Haven (Nursing Care)	Valley View Terrace (Supportive Care)	Malta Home Nursing Care
Private _____	A Style Suite _____	Private _____
Semi-Private _____	B Style Suite _____	Semi-Private _____
	C Style Suite _____	
	Studio _____	

I desire admission: Immediately: _____ At a later date _____ *(applicant must contact us in the future)*

Reason for seeking admission: _____

How did learn of our retirement community? _____

I. Demographics Section 1:

Applicant's Name: _____ Gender: _____
Last First Middle Title Suffix

Current Address: _____
Street Town State Zip Code

Telephone No.: _(_____) _____ Years at current address: _____

Marital Status: Single _____ Married _____ Widowed _____
Date Date

Divorced _____ Separated _____
Date Date

Date of Birth: _____ Age: _____ Social Security. No.: _____

II. Demographics Section 2:

Spouse's Name: _____ Telephone No.: _(_____)_____

Spouse's Address: _____
Street Town State Zip Code

Church Name: _____ Religious Denomination: _____

Pastor's Name: _____ Pastor's Telephone No.: _(_____)_____

Pastor's Address: _____
Street Town State Zip Code

Birthplace: _____ Citizen of: _____

Language: _____ Maiden Name: _____

Veteran? _____ Military Branch: _____ Years of Service _____

Education (Highest): _____ Former or Present Occupation: _____

List Your Current Hobbies, Talents, or Special Interests: _____

Prepaid Burial Reserve:

Name of Financial Institution: _____

Dollar Amount Reserved: _____ Is the Agreement irrevocable? Yes _____ No _____

Funeral Home: _____ Telephone No.: _____

Funeral Home Address:

_____ Street Town State Zip Code

Living Will? Yes _____ No _____ *(Please provide copy upon admission)*

Exercise Right to Vote? Yes _____ No _____

II. Demographics Section 2 (Continued):

EMERGENCY CONTACTS:

First Contact (First person notified in case of an emergency):

Name: _____ Home Phone No.: _____
Address: _____ Work Phone No.: _____
Address: _____ Cell Phone No.: _____
Relationship (e.g., Daughter/POA, Guardian): _____

Second Contact (Notified When the First Contact Cannot Be Reached):

Name: _____ Home Phone No.: _____
Address: _____ Work Phone No.: _____
Address: _____ Cell Phone No.: _____
Relationship (e.g., Daughter/POA, Guardian): _____

Third Contact (Notified When the First & Second Contacts Cannot Be Reached):

Name: _____ Home Phone No.: _____
Address: _____ Work Phone No.: _____
Address: _____ Cell Phone No.: _____
Relationship (e.g., Daughter/POA, Guardian): _____

OTHER CONTACTS:

Name: _____ Home Phone No.: _____
Address: _____ Work Phone No.: _____
Address: _____ Cell Phone No.: _____
Relationship (e.g., Daughter/POA, Guardian): _____

Name: _____ Home Phone No.: _____
Address: _____ Work Phone No.: _____
Address: _____ Cell Phone No.: _____
Relationship (e.g., Daughter/POA, Guardian): _____

IV. Insurance Information:

1. Are you enrolled in Medicare? Yes _____ No _____ Medicare No.: _____
 Part A (*Hospitalization*)? Yes _____ No _____ Part B? Yes _____ No _____
2. Are you enrolled in a Medicare HMO? Yes _____ No _____
 Name of HMO _____ Phone: _(____)_____
 HMO Id. No.: _____ Primary Care Physician: _____
3. Do you have Medi-Gap Coverage (*for example, Blue Cross Security 65?*) Yes _____ No _____
 Name of Company: _____ Insured's ID No.: _____
 Plan Type (circle one): A B C H Group No., if any: _____
4. Do you receive Medical Assistance? Yes ____ No ____ County: _____
 Med. Assistance Recipient No.: _____ Expiration Date: _____
5. Do you have other Health Insurance Coverage? Yes ____ No ____ Policy No.: _____
 Name of Company: _____ Telephone: _(____)_____
 Name of Company: _____ Telephone: _(____)_____

V. Financial Information (Please use whole dollar figures only):

A. Assets**:	Amount	Bank Name (if bank account)	Owners
Market Value of Real Estate*	\$ _____	_____	_____
Checking Accounts	\$ _____	_____	_____
Saving Accounts	\$ _____	_____	_____
Certificates of Deposit	\$ _____	_____	_____
Stocks & Bonds	\$ _____	_____	_____
Mutual Funds	\$ _____	_____	_____
Debts Others Owe to You	\$ _____	_____	_____
Other: _____	\$ _____	_____	_____
Other: _____	\$ _____	_____	_____

* The market value of Real Estate is based on: ____ Appraisal ____ Your Estimate

V. Financial Information (Continued -Please use whole dollar figures only):

B. Liabilities**:	Amount	Bank Name (if bank debt)
Mortgages on Real Estate	\$ _____	_____
Outstanding Loans or Notes	\$ _____	_____
Other: _____	\$ _____	_____
Other: _____	\$ _____	_____
Other: _____	\$ _____	_____

<u>C. Monthly Income**:</u>	<u>Amount</u>
Social Security	\$ _____
Pension or Retirement	\$ _____
Annuities	\$ _____
Interest & Dividends	\$ _____
Rental Income	\$ _____
Supplemental Security Income	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____

D. Have any of your assets been transferred to other individuals or organizations within the past five (5) years? Yes _____ No _____ If yes, please indicate what was transferred, who the resources were transferred to, and the value or amount transferred (*please attach sheet*).

**Supporting documentation (such as tax returns and/or bank statements) may be requested.

VI. Medical Information

A. Hospital and Physicians:

1. Hospital Preference:

- _____ Lewistown Hospital
- _____ J.C. Blair Memorial Hospital
- _____ Centre Community Hospital

2. Ambulance Company: _____

3. Physician's Name: _____ Telephone: _(_____)_____

Address: _____

VI. Medical Information (Continued)

4. Dentist's Name: _____ Telephone: _(____)_____
- Address: _____
5. Ophthalmologist's/
Optometrist's Name: _____ Telephone: _(____)_____
- Address: _____
6. Podiatrist's Name: _____ Telephone: _(____)_____
- Address: _____
7. Other Physician/
Specialist's Name: _____ Telephone: _(____)_____
- Address: _____

B. Diet

1. Please Check all that apply:

- | | | | |
|------------|-------|-----------|-------|
| Regular | _____ | Ground | _____ |
| Diabetic | _____ | Soft | _____ |
| Low Sodium | _____ | Blended | _____ |
| Low Fat | _____ | Liquid | _____ |
| | | Allergies | _____ |

2. If Diabetic or Low Sodium, please explain: _____
- _____
3. If there are Allergies, please explain: _____
- _____
4. Food Dislikes: _____
- _____

C. Physical Condition

1. Please check all that apply (*if you have questions, please check with your doctor*):

- | | |
|--------------------------|---------------------------|
| _____ Heart Trouble | _____ High Blood Pressure |
| _____ Tuberculosis | _____ Alzheimer's Disease |
| _____ Epilepsy | _____ Senile Dementia |
| _____ Cancer | _____ Emphysema |
| _____ Diabetes | _____ Asthma |
| _____ Contagious Disease | _____ Glaucoma |
| _____ Paralysis | _____ Physical Deformity |
| _____ Decubitus | |

VI. Medical Information (Continued)

2. If any of the above are checked, please explain _____

3. Describe in full, any illness, physical limitations or recent operations _____

4. Current Medications _____

5. List any Medications Allergies _____

6. Immunizations:

	<u>Date Received</u>	<u>Name of Physician/Other Provider</u>
Pneumococcal	_____	_____
Tetanus	_____	_____
Influenza	_____	_____

7. Most recent hospitalization:

a. Dates: Beginning _____ Ending _____

b. Hospital Name: _____

c. Social Worker's Name: _____

8. Is the applicant currently receiving any Home Health Nursing or Rehabilitative Services?

Yes _____ No _____ If yes, please explain _____

9. Is the applicant currently using medical equipment? Yes _____ No _____

If yes, describe _____

Is Medicare Part B currently paying for this equipment? Yes _____ No _____

VI. Medical Information (Continued)

10. History of Mental Illness? ? Yes _____ No _____

If yes, describe _____

11. Has the applicant ever been hospitalized for mental illness?

If yes, when and where? _____

12. Does the applicant smoke? Yes _____ No _____ If yes, how often? _____

13. Does the applicant require any treatment relating to alcohol or drug addiction?

Yes _____ No _____ If yes, please explain _____

VII. Activities of Daily Living and Personality:

A. Speech: Can be understood _____ Difficult to understand _____
Does not talk _____ Had therapy _____ Needs therapy _____

B. Hearing: Good _____ Impaired _____ Deaf _____ Hearing Aid _____

C. Sight: Good _____ Impaired _____ Blind _____ Glasses _____

D. Feeding: Independent _____ Needs Help _____ Must be fed _____
Nasal Tube _____ Gastro Tube _____

E. Bladder: Continent _____ Occasional Incontinence _____
Incontinent (*no control*) _____ Catheter _____
Ostomy, please specify _____

F. Bowels: Continent _____ Occasional Incontinence _____
Incontinent _____ Ostomy, please specify _____

G. Ambulation: Alone _____ With 1 person assisting _____
With 2 persons assisting _____ Bed to chair _____ Bed bound _____

H. Locomotion: Independent _____ Cane _____ Walker _____ Wheelchair _____ Geri-chair _____

I. Prosthesis: (*Please specify*) _____

VII. Activities of Daily Living and Personality (Continued):

- J. Dental: Dentures _____ Partial Dentures _____
Own Teeth _____ Other _____
- K. Grooming: Independent _____ Needs Assistance _____ Total Care _____
- L. Dressing: Independent _____ Needs Assistance _____ Total Care _____
- M. Height _____ Weight _____
- N. Oriented: Always _____ Confused at times _____ Always Confused _____
- O. Decision Making: Independent _____ Needs Assistance _____
Unable to make decisions _____
- P. Alert: Aware of surroundings _____ Sleeps Often _____ Comatose _____
- Q. Conversation: Talkative _____ Normal _____ Quiet _____
- R. Emotional:
- | | | | |
|--|-------|-----------------------------------|-------|
| 1. Usually has a positive attitude | _____ | Tends to have a negative attitude | _____ |
| 2. Tends to be withdrawn | _____ | Is usually interested in others | _____ |
| 3. Is usually confident | _____ | Tends to be fearful | _____ |
| 4. Is irritable and depressed at times | _____ | Tends to be pleasant and happy | _____ |
| 5. Is usually realistic | _____ | Tends to imagine things | _____ |
| 6. Can be defensive | _____ | Is usually easy going | _____ |
| 7. Usually has a good memory | _____ | Tends to be forgetful | _____ |

I understand that Valley View Retirement Community and Malta Home Retirement Community retain the right to accept or reject any application consistent with the law. I certify that all of the information submitted on this application is true and correct, and I understand the submission of false information may constitute grounds for rejection of this application or my discharge after admission.

Date

Signature of Applicant or Responsible Party