214 Peach Orchard Road, McConnellsburg, PA 17233
717-485-3155

Long Term Care Application

Name_____ **Date of Birth**_____ **Age**_____
Address _____ **Phone**_____
Township: _____ County_____ Birthplace_____
Marital Status: ☐ M ☐ W ☐ S ☐ D **Sex:** ☐ Male ☐ Female **Social Security #**_____

POWER OF ATTORNEY _____
**Copy needed* NAME RELATIONSHIP

_____
ADDRESS PHONE

POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE MEDICAL DECISIONS	**YES** ☐	**NO** ☐
POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE FINANCIAL DECISIONS	**YES** ☐	**NO** ☐
DOES APPLICANT HAVE A LIVING WILL? *If yes, please provide us a copy.	**YES** ☐	**NO** ☐

Two (2) persons to contact in case of emergency <u>other than POA</u>:

NAME RELATIONHIP

ADDRESS

HOME PHONE OTHER PHONE

NAME RELATIONSHIP

ADDRESS

HOME PHONE OTHER PHONE

List other relatives/special friends who may receive medical information::

PHYSICIAN_____
NAME ADDRESS PHONE

DENTIST_____
NAME ADDRESS PHONE

OPTOMETRIST_____
NAME ADDRESS PHONE

CLERGY & CHURCH_____
NAME ADDRESS PHONE

FUNERAL DIRECTOR_____
NAME ADDRESS PHONE

BURIAL PLOT/CEMETARY? IS YOUR BURIAL PREPAID?

WHO WILL BE RESPONSIBLE FOR YOUR ESTATE?

Social Information

WHAT ARE PRESENT LIVING ARRANGEMENTS? _____

WHY DO YOU NEED LONG TERM CARE AT THIS TIME? _____

LENGTH OF STAY? □ Short Term (LESS THAN 6 MONTHS) □ Long Term GREATER THAN 6 MONTHS)

If SHORT TERM, WHAT ARRANGEMENTS WILL YOU HAVE UPON DISCHARGE?

□ HOME □RELATIVE'S HOME □ PERSONAL CARE HOME □ OTHER_____

DO YOU RECEIVE HOME HEALTH SERVICES? □ Yes □ No
If YES, SPECIFY: _____

DO YOU RECEIVE PRIVATE DUTY SERVICES? □ Yes □ No
If YES, SPECIFY: _____

DO YOU RECEIVE SERVICES FROM AREA AGENCY ON AGING? □ Yes □ No
If YES, SPECIFY: _____

DO YOU OWN/RENT YOUR EQUIPMENT? **□ YES □ NO**

□ WHEELCHAIR: □ OWN □ RENT FROM _____
□ HOSPITAL BED: □ OWN □ RENT FROM _____
□ WALKER: □ OWN □ RENT FROM _____
□ BEDSIDE COMMODE: □ OWN □ RENT FROM _____
□ CANES □ OWN □ RENT FROM _____
□ OTHER: ._____

WHO WILL PROVIDE TRANSPORTATION TO OUTSIDE MEDICAL APPOINTMENTS? _____

_____

HIGHEST LEVEL OF EDUCATION/SCHOOLS ATTENDED _____

LIFETIME OCCUPATION _____
WORK SCHEDULE: _____

HOBBIES/INTERESTS _____

WHAT RECREATIONAL ACTIVITY WOULD YOU LIKE TO PURSUE DURING YOUR STAY? _____

_____

DO YOU HAVE PETS? □ YES □ NO IF YES, SPECIFY_____

PERSONAL HABITS: □ SMOKER □ CHEWING TOBACCO □ALCOHOL USE □ OTHER _____

Describe Daily Routine (eating, sleeping, bathing, etc…) _____

_____

_____

Medical Information

CURRENT DIAGNOSIS:

ALLERGIES? □ Yes □ No IF YES, SPECIFY _____

VACCINATIONS:

□ Seasonal Flu- Date: _____ □ H1N1- Date:_____
□ Pneumonia- Date: _____ □ Tetanus- Date: _____

*****PLEASE ATTACH LIST OF CURRENT MEDICATIONS.**

DATE OF LAST OFFICE PHYSICIAN VISIT _____
REASON: _____

OTHER NURSING HOME ADMISSIONS (SPECIFY DATES): _____
_____

MOST RECENT HOSPITAL IZATIONS

	HOSPITAL	REASON	DATES
1.			
2.			
3.			

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSIS?

□ CANCER	□ SCHIZOPHRENIA	□ PANIC/ANXIETY	□ QUADRIPLEGIA
□ FRACTURE	□ SUICIDE	□ AUTISM	□ PSYCHOTIC DISORDER NOS
□ STROKE	□ DRUG ABUSE	□ ENCEPHALITIS	□ PERSONAILITY DISORDER
□ TUBERCULOSIS	□ ALCOHOL ABUSE	□ SPINA BIFIDA	□ BLINDNESS & DEAFNESS
□ HYPERTENSION	□ CEREBRAL PALSY	□ HYDROCEPHALUS	□ TOURETTES'S SYNDROME
□ MENNINGITIS	□ POLIO	□ MULTIPLE SCLEROSIS	□ ANOXIC BRAIN DAMAGE
□ HEAD INJURIES	□ BI-POLAR	□ DEPRESSION	□ EPILEPSY/SEIZURES
□ DELUSIONS	□ PARANOIA	□ PARAPLEGIA	□ SOMATOFORM DISORDER

□ ANOTHER MENTAL HEALTH DISORDER THAT MAY LEAD TO CHRONIC DISABILITY
□ MENTAL RETARDATION:
Services received: _____
□ OTHER INJURIES: _____
□ PSYCHIATRIC HOSPITALIZATIN: _____
facilities and dates
□ SUICIDE ATTEMPTS: _____
Date of attempts

Nursing Needs

AMBULATION: □ WALKS ALONE □ WALKS WITH ASSISTANCE □BED TO CHAIR ONLY □NON-AMBULATORY

FALL HISTORY: □ Past 30 days □ Past 2-6 months □ Fracture within past 6 months

PATIENT AIDS: □WALKER □ WHEELCHAIR □ CANE □BRACE □ CRUTCHES □ OTHER_____

ORIENTATION: □ ORIENTED: □ PERSON □ PLACE □ TIME □ SITUATION □ SOMETIMES CONFUSED □ ALWAYS CONFUSED

COMMUNICATION: □ VERBAL □ NON VERBAL □ GESTURES □ SIGN LANGUAGE OTHER LANG. SPOKEN: _____

BEHAVIOR: □ WELL ADJUSTED □ DEPRESSED □ COOPERATIVE □ HOSTILE □ COMBATIVE □ WITHDRAWN
□ WANDERS □ OTHER: _____

BOWEL/BLADDER:

□USES BATHROOM ALONE	□NEEDS HELP	□CATHETER
□COLOSTOMY	□INCONTINENT OF URINE	□INCONTINENT OF FECES
□OCCASIONAL INCONTINENCE	□USES BEDPAN	□ USES BEDSIDE COMMODE
□CONSTIPATION	□LAXATIVE TAKEN AT HOME	

SKIN: □ OPEN AREAS □ RED AREAS ANY SPECIAL PROBLEMS? _____

DRESSING: □ DRESSES SELF □ DRESSES WITH SUPERVISION □ MUST BE DRESSED
List specifics: _____

BATHING: □ BATHES SELF □ BATHES WITH HELP □TUB □SHOWER □ COMPLETE BED BATH
Time of Day: _____ How often: _____

SLEEP SCHEDULE: Awakens at: _____ Retires at: _____ Other sleep habits: _____

EYESIGHT: □ NORMAL □ GLASSES □ BLIND □ NEED LARGE PRINT

HEARING: □ NORMAL □ HARD OF HEARING □ DEAF RIGHT EAR □ DEAF LEFT EAR □ HEARING AIDS

DENTATION: □ OWN TEETH □ UPPER DENTURES □ LOWER DENTURES

DIET: □ REGULAR DIET □ SPECIAL DIET □ POOR APPETITE □ FEEDS SELF □ MUST BE FED
□ REQUIRES HELP □ TUBE FEED □ OTHER: _____
FOOD PREFERENCES _____ FOOD INTOLERANCES _____

Financial

(MUST BE COMPLETED OR APPLICATION WILL NOT BE PLACED IN RESOURCE POOLE.)

PRSENT INCOME **MONTHLY VALUE**

□ SOCIAL SECURITY---------- $_____
□ SUPPLEMENTAL SECURITY INCOME---------- $_____
□ PRIVATE PENSIONS _____ $_____
□ INTEREST INCOME_____ $_____
□ OTHER _____ $ _____

Financial Assets

□ BANK CHECKING ACCOUNT_____ $_____
□ BANK SAVINGS ACCOUNT _____ $_____
□ REAL ESTATE_____ $_____
□ SAVINGS BONDS, STOCKS, CERTIFICATES _____ $_____
□ OTHER _____ $_____

HAVE ANY ASSETS BEEN TRANSFERRED IN THE PAST (FIVE) YEARS? **YES** □ **NO** □
If yes, give description of transfer and provide date: _____

WHO WILL RECEIVE BILLING AND FINANCIAL INFORMATION?_____

Insurance Information

□ MEDICARE #_____HOSPITAL (PART A) Date: _____ MEDICAL (PART B) Date: _____

□ SECONDARY INSURANCE: _____CONTRACT #_____ GROUP #_____

□ MEDICAL ASSISTANCE #_____

□ PACE □ PRESCRIPTION PLAN: _____ Member ID: _____ RxBIN: _____ RxPCN:_____ RxGrp: _____

CURRENT PHARMACY: _____PHONE #_____

LONG TERM CARE INSURANCE: NAME OF POLICY _____ POLICY #_____

LIFE INSURANCE:
NAME _____ POLICY #_____ DATE ACQUIRED:____ FACE VALUE:_____CASH VALUE:_____
NAME _____ POLICY #_____DATE ACQUIRED:____ FACE VALUE:_____CASH VALUE:_____

BURIAL ASSOCIATIONS

SIGNATURE OF PERSON COMPLETING APPLICATION _____DATE:_____

ADDRESS PHONE RELATIONSHIP TO APPLICANT

WHO SHOULD BE CONTACTED FOR ADMISSION? _____