

Pre-Admission Application

Every Life Has Meaning...



Living The Quaker Tradition

99 Barclay Street Newtown, PA 18940 215-497-0905 FAX 215-504-4407

This is not an agreement and is issued for information only. PLEASE PRINT.

PERSONAL INFORMATION

DATE: _____

POTENTIAL RESIDENT

Name _____
Last First Middle

CURRENT ADDRESS: _____

City _____ State _____ Zip _____

Telephone Number (_____) _____

Birth Date ____/____/____ Hair Color _____ Eye Color _____
month day year

Social Security _____ - _____ - _____ Medicare # _____

Marital Status:

- Single
- Married
- Divorced
- Separated
- Widowed

Year Widowed:

Areas Interested in:

- Adult Day Health Program
- Community Living
- Hicks Personal Care
- Friends Nursing Home
- Respite
- Residential Apartments
- Cottages/Lofts

PRIMARY INSURANCE: Check One Medicare ; Other

If Other, Name _____ Policy # _____ Group # _____

Address _____

Telephone # _____ Subscriber _____

SECONDARY INSURANCE: Name _____ Policy # _____ Group # _____

Address _____

Telephone # _____ Subscriber _____

Have Advance Directives/Living Will been completed? YES NO

Has a durable medical power of attorney been designated? YES NO

Name _____ Telephone # _____

Has a durable financial power of attorney been designated? YES NO

Name _____ Telephone # _____

Current Physician: _____ Telephone # _____

Hospital Preferred: _____

Most Recent Hospitalization: _____

Date _____ Place _____

Reason

How did you hear about Chandler Hall? Hospital Physician Word of Mouth Live Locally Social Worker

Other Chandler Hall Program, please list: _____ Newspaper, please list: _____

Other, please list: _____

EMERGENCY INFORMATION: (Please Print)
List two people to notify in case of emergency.

Name _____ Relation _____ Name _____ Relation _____

Address _____ Address _____

Home Phone # _____ Work _____ Home Phone # _____ Work _____

Cell Phone #: _____ Cell Phone # _____

Email: _____ Email: _____

LIVING ARRANGEMENT PRIOR TO ADMISSION: Home Alone Home Alone with Caregiver Home with Home Care

(Optional)
Religion/Affiliation: _____ Place of Worship: _____
Pastor/Rabbi: _____ Telephone Number: (____) _____

Home with Other Assisted Living/Personal Care Home Nursing Home Home and attending Adult Day Program
 Home and attending Senior Center Other(Explain) _____

PERSONAL HISTORY

Reason for coming to Chandler Hall (your expectations):

Life Review: Born/Raised: _____ Marriage: _____

Children: _____ Grandchildren: _____

Work/Occupation: _____

Education: Less than 12 High School Graduate Some College College Graduate
 Post Graduate Unknown

Life interests/Accomplishments/Special life events: _____

RECREATION: (Check Preferences) Cards/Other Games Crafts/Arts Exercise/Sports Music
 Reading/Writing Nature Gardening
 Houskeeping/Cooking Needlework/Sewing Trips/Shopping
 Spiritual/Religious Activities Photography Watching TV
 Walking/Wheeling Outdoors Collections Travel
 Other: _____

If pre planned Funeral arrangements been made please complete:

Name of Funeral Home: _____ Phone _____
Address: _____ City _____ State _____ Zip _____

If pre planned Funeral arrangements have not been made, who would make arrangements? _____

HEALTH REVIEW

(Those applying for Adult Day Health Program should skip this page)

Directions: Please check to indicate recent problems in any of the following areas.

This does not have to be completed by your physician.

HEAD AND NECK:

- Headaches Sinus disease Enlarged glands Skin disease Ear disease Hearing Impairment Hearing Aid
 Eye disease Impaired vision Date last eye exam: _____ Other: _____

RESPIRATORY:

- Cough Shortness of breath Sputum Hemoptysis Wheezing Asthma Bronchitis Emphysema Pneumonia
 Tuberculosis Pleurisy Other: _____

CARDIAC:

- Heart trouble High blood pressure Rheumatic fever Heart Murmurs Dyspnea Orthopnea PND
 Edema Chest Pain Palpitations Past EKG or other heart tests Other: _____

GASTROINTESTINAL:

- Appetite: _____ Weight gain/loss Difficult swallowing Nausea Vomiting Indigestion Abdominal pain
 Diarrhea Constipation Laxative use: _____ Change in bowel habits Rectal bleeding
 Hemorrhoids Hernia Special diet: _____ Other: _____

GENITOURINARY:

- Difficulty Nighttime urination(times per night): ____ Leaking of urine Blood in urine Painful urination Sexual function problems:
Women: Vaginal discharge or irritation Last Pap test: ____ Age at Menopause ____ Last Mammogram: ____ Number of Pregnancies: ____
Men: Prostrate trouble Discharge from penis Other: _____

EXTREMITIES:

- Joint or back pain Stiffness Arthritis Swelling Leg Pain Rash problems Skin Problems Cramping
 Varicose veins Blood Clots Other: _____

NEUROLOGICAL:

- Weakness Fatigue Numbness Tingling Dizziness Balance trouble Falls Tremors Shakiness
 Fainting spells Nervousness Tension Mood Depression Forgetfulness Disruptive Behavior Wandering
 Other: _____

HEMATOLOGIC:

- Anemia Easy bruising Bleeding Past transfusions, Last Date: _____ Blood thinning medications
 Other: _____

ENDOCRINE:

- Thyroid trouble Heat or cold intolerance Excessive sweating Diabetes Excessive thirst Hunger Urination
 Other: _____

LIST OF CURRENT MEDICATIONS

Medication Name	Dosage (Strength)	Frequency (Times Per Day)

HABITS: **Smoking:** Currently, how much: _____ Past, when stopped: _____ Never
Alcohol Use: Regularly Occasionally Rarely Never
Caffeine: Regularly Occasionally Rarely Never
Exercise: Regularly Occasionally Rarely Never
Insomnia: Regularly Occasionally Rarely Never

OPERATIONS/ADULT ILLNESS:

Describe Medical History/Diagnoses: _____

INJURIES: Fractures _____ Other: _____

VACCINATIONS: Last Flu vaccination: _____ Pneumovax: _____ Last Tetanus Booster: _____

ALLERGIES to medications, x-ray dyes, insect bites, food, or other substances, please list: _____

OTHER: Able to feed self Able to feed self if cued or food is cut and prepared Able to dress self
 Is potential resident continent Able to walk independently Memory Trouble: (for _____ months)

Thank you for completing this application. **Please note:** For Admission to *The Hicks Residence, Community Living* or *Residential Living*, there is a one-time non-refundable *Community Fee* of _____ due upon admission. This *Fee* does not apply to the Friends Nursing Home. Please do not submit checks or money with this application.

Date _____ Signature of Applicant: _____

If applicant is unable to sign, signature of Responsible Party _____

Date: _____ Relationship to Applicant: _____

Chandler Hall services do not include guaranteed life care as reflected by Fee Schedules. Schedules are available upon request. Transfers between levels of care are on a space-available basis and subject to approved assessment.



FINANCIAL INFORMATION

Name _____ Date: _____

Marital Status: Single Separated Married Divorced Widowed

ASSETS

Name of Bank _____ Balance \$ _____ Account: Single Joint
 If joint, list other names _____

Name of Bank _____ Balance \$ _____ Account: Single Joint
 If joint, list other names _____

Stocks & Bonds If yes, list current holdings _____ \$ _____ Account: Single Joint
 _____ \$ _____ Account: Single Joint
 _____ \$ _____ Account: Single Joint

Real Estate

(Address) _____ \$ _____ Ownership: Single Joint

If joint, list other names _____

Is Real Estate currently on the market? Yes No Has it been appraised? Yes No

Current Occupant/Relationship _____

Real Estate

(Address) _____ \$ _____ Ownership: Single Joint

If joint, list other names _____

Is Real Estate currently on the market? Yes No Has it been appraised? Yes No

Current Occupant/Relationship _____

Other Assets (please describe nature of other assets and whether ownership is single or joint):

_____ \$ _____

Total Assets: \$ _____

LIABILITIES

Please describe nature of **any** liabilities: _____ \$ _____
 (including mortgages, credit cards, loans, etc)

_____ \$ _____

_____ \$ _____ **Total Liabilities: \$** _____

INCOME (Monthly or Monthly average of regular income)

Social Security \$ _____ Annuities \$ _____ Pension \$ _____

Interest Dividends \$ _____ Other \$ _____ Other \$ _____

Total Monthly Income: \$ _____

How do you expect to pay for care now? _____

In three years? _____

How do you expect to pay for changes in level of care/needs? _____

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I confirm that the above information is complete and correct.

 Signature of Applicant/Date

 Signature of Person Completing Form for Applicant/Date



Resident

PLEASE CHECK ALL THAT APPLY IN THE PAST YEAR

VISION (Ability to see in adequate light and with glasses if used)

- ADEQUATE - sees fine detail, including regular print in newspapers/books
- IMPAIRED - sees large print, but not regular print in newspapers/books
- MODERATELY IMPAIRED - limited vision; not able to see newspaper headlines, but can identify objects
- HIGHLY IMPAIRED - object identification in question, but eyes appear to follow objects
- SEVERELY IMPAIRED - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

VISUAL APPLIANCES (Does resident wear glasses or contacts?)

- No Yes

HEARING (With hearing appliance, if used)

- HEARS ADEQUATELY - normal talk, TV, phone
- MINIMAL DIFFICULTY - when not in quiet setting
- HEARS IN SPECIAL SITUATIONS ONLY - speaker has to adjust tonal quality and speak distinctly
- HIGHLY IMPAIRED - absence of useful hearing

COMMUNICATION DEVICES TECHNIQUES

- Hearing aid, present and used
- Hearing aid, present but not used regularly
- Other receptive communication techniques used (e.g., lip reading)
- NONE OF THE ABOVE

CUSTOMARY ROUTINE CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 p.m.)
- Naps regularly during day (at least 1 hour)
- Goes out 1+ days per week
- Stays busy with hobbies, reading, or fixed daily routine
- Spends most of time alone or watching TV
- Moves independently indoors (with appliances, if used)
- Use of tobacco products at least daily
- NONE OF THE ABOVE

ACTIVITY OF DAILY LIVING (ADL) PATTERNS

- In bedclothes much of day
- Wakens to toilet all or most nights
- Has irregular bowel movement pattern
- Showers for bathing
- Bathing in PM
- NONE OF THE ABOVE

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends
- Usually attends church, temple, synagogue (etc.)
- Finds strength in faith
- Daily animal companion/presence
- Involved in group activities
- NONE OF THE ABOVE

EATING PATTERNS

- Distinct food preferences
- Eats between meals all or most days
- Use of alcoholic beverage(s) at least weekly
- NONE OF THE ABOVE

Person Completing Form

Relationship

Date

Insert A