

EAGLE VALLEY PERSONAL CARE HOME, INC
Admission Application

Please provide all information requested. Additional information may be required when the application is processed. Please inform the Resident Care Coordinator if information changes significantly after the application has been submitted.

PLEASE PRINT

Applicant: _____ Maiden Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason for Making Application for Admission:

CONTACT INFORMATION

Primary Contact: Name: _____ Relationship: _____

Person Responsible for Financial Issues: POA: ___ No ___ Yes

Address: _____ City: _____ State: _____ Zip: _____

Phone contact: Home: _____ Cell: _____ Work: _____

Person Responsible for Medical Issues: Living Will ___ No ___ Yes Durable Health POA: ___ No ___ Yes

Name: _____ Relationship to Applicant: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone contact - Home _____ Cell _____ Work _____

Other Personal Contacts

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Contact: Home _____ Cell _____ Work _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Contact: Home _____ Cell _____ Work _____

SOCIAL INFORMATION

Birth Date: _____ U.S. Citizen: _____ Primary Language _____

Line of Work _____ Retired: _____

Religious Affiliation: _____ Place of Worship _____

Minister/Priest Name _____

Names of Children: _____

Military Service: Applicant or Spouse

Branch _____ Rank: _____ Date Spouse's Death _____

Does Applicant have a driver's license _____ or Gov. Issued Photo ID _____

Does Applicant plan to bring vehicle with him/her Yes _____ No _____

Tobacco Use: _____ Alcohol use: _____ Drug dependence _____

Profile Pending legal action _____ Past felony conviction _____ History drug/alcohol abuse _____

Financial Resources Information – Use Separate sheet if necessary

Monthly Social Security: \$ _____ Pension: \$ _____

Other income: From: _____ Monthly Amount: \$ _____

Estimate: Savings: \$ _____ Checking: \$ _____ Stocks/bonds: \$ _____ IRS Plan: \$ _____

Home/Real Estate: Describe _____ Estimate Value: _____

Other Assets: Type: _____ Value: \$ _____ Type: \$ _____ Value: \$ _____

Outstanding Liabilities: (Mortgages, Car Loans, Credit Card Debt, etc) \$ _____

MEDICAL INSURANCE - Primary Medical Insurance: _____ **ID#** _____

Medicare #: _____ **Social Security #** _____

Medicare D Plan & ID# _____

Medical Supplemental Plan _____ ID# _____

HEALTH CARE DECISIONS –

Primary Care Physician: _____ Other Specialist _____

Dentist: _____ Eye Doctor: _____ Podiatrist: _____

Ambulance Membership: _____

Funeral Director: _____ City: _____ Prepaid Arrangement: __No __Yes

PERSONAL CARE ABILITIES & GENERAL HEALTH INFORMATION

Walking: Independent: ___ Cane:___ Walker:___ Needs Assistance:___ Not able to walk:___
Not able to stand:___

Wheelchair use: All times:___ Distance only:___ Propels self:___ Has wheelchair:___
Motorized chair/scooter:___

Speech: Clear:___ Difficulty speaking:___ Difficult to Understand:___ Alternate Language:_____

Hearing: No Impairment: ___ Hard of Hearing:___ Deaf: ___ Hearing aids: ___ Rt Ear:___ Lt Ear: ___

Sight: No Impairment: ___ **Glasses:** All times: ___ Reading Only:___ Contact Lenses:___ Eye color:_____
Specific Visual Limitations/eye conditions: _____

Toilet function: Independent: ___ Needs help to use toilet or with personal hygiene: ___ Day:___ Night:___

Bladder Control – No problems:___ Occasional lack control:___ Frequent lack control:___ Catheter:_____
Wears protective garment:_____ Self Manages protective garment:___ Needs assistance with garment: ___

Bowel Function: - No problems:___ Occasional lack control:___ Frequent lack control:___
Frequent constipation:___ Frequent Diarrhea:___ Colostomy:_____

Eating – Independent:___ Needs Assistance: ___ Adaptive Utensils:___ Dentures: ___ Upper:___ Lower:___
Diet restrictions: _____ Usual diet:_____

Bathing – Bathes self:_____ Requires Assistance: _____

Grooming/Dressing – Self care:___ Requires Minimal Assistance: ___ Requires considerable assistance: ___
Hair color:_____

Identifying Marks: (scars, moles, birthmarks etc.) _____

Mental Capacity – Alert all times: ___ Able to make own decisions:___ Needs help with decisions:___

Memory good: ___ Forgets: Occasionally :___ Often:___ Memory very poor:___

Describe cognitive problems, inappropriate behavior, wandering:

Describe treatment/hospitalization for mental health issues:

Medical Equipment: _____

Home Health Agency Preference: _____

CURRENT MEDICAL CONDITIONS: (may submit list)

Check all: Pacemaker:___ Seizures:___ Chest Pain: ___ Breathing Problems:___ Prosthesis ___

Allergies: Medication, food & others:_____

Major Surgeries: _____

Most Recent Hospitalization/reason: _____

CURRENT MEDICATIONS: Please Provide a List – Prescription, Over the counter, Herbal

Any other relevant information:

Additional Information

- A. Pre-screening evaluation: Within thirty days prior to admission, you must have a standardized screening, including a mobility assessment, to determine if Eagle Valley PCH, Inc can provide the proper level of care for you. This screening, which is required by law, will be completed by a representative from Eagle Valley PCH Inc..
- B. Medical Evaluation: Prior to admission, you must have a medical evaluation completed by your physician. He will determine what level of care you need. You must be re-evaluated by your physician annually or if there has been a change in your health.
- C. Resident Agreement: Prior to or on the day of admission, you must sign the resident agreement which requires, among things, your agreement to comply with the House Rules of Eagle Valley PCH Inc..
- D. Resident Assessment: Within 15 days of admission, the State of Pennsylvania requires that we complete a resident assessment form. This will be presented to you and your input is necessary for its completion. A copy will be provided if you or your designee requests one. Your signature will be required on this form.
- E. Resident Support Plan: The State of Pennsylvania requires a resident support plan be initiated within 30 days of admission. This will be presented to you and your input is necessary for its completion. Your signature will be required on this form. A copy will be provided if you or your designee requests one.
- F. A living will is not required but strongly suggested.
- G. Please bring along on day of admission all insurance cards including but not limited to Medicare, supplemental plan and prescription coverage.

I understand the need for initial then yearly medical evaluations, assessments and updated support plans. I understand the Resident Rights and how to report if my rights have been violated. I understand I can refuse or question a medication if I feel the medication is not correct.

I understand that Eagle Valley PCH Inc. retains the right to accept or reject any application consistent with the law. I certify that all 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 discharge after admission.

Applicant's Signature:_____Date:_____

Designated Person Signature:_____Date:_____