EAGLE VIEW PERSONAL CARE HOME, LLC.
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 View Personal Care Home, LLC. can provide the proper level of care for you. This screening, which is required by law, will be completed by a representative from Eagle View Personal Care Home, LLC.
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 View Personal Care Home, LLC.
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 View Personal Care Home, LLC. 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:____________________________