



2990 Carlisle Pike, New Oxford, PA 17350
(717) 624-2161 www.crosskeysvillage.org

Mission Statement
A Brethren ministry dedicated to
enriching the lives of older adults

APPLICATION FOR ADMISSION TO HEALTHCARE CENTER OR PERSONAL CARE

The information asked for on this form is needed to evaluate a prospective resident's request for admission. All information provided will be held in strict confidence. Submission of this form does not bind either party to admission. If you are completing this application on behalf of another person, please answer each question with regard to the prospective resident.

This application is for admission to:

- | | |
|---|---|
| <input type="checkbox"/> Short Term Nursing Care or Rehab | <input type="checkbox"/> Long Term Personal Care |
| <input type="checkbox"/> Long Term Nursing Care | <input type="checkbox"/> Memory Support or Secure Personal Care |

Wishes admission:

- Now (at discharge from hospital, or as soon as a room becomes available)
 Later (planning for the future)

1. Full name of Applicant: _____
(First) (Middle) (Last)

2. Sex: Male Female

3. Date of birth: _____

4. Marital status: Single Widowed Married Divorced Separated

5. Current address of Applicant: _____
(Street) (Apt#)

(City) (State) (Zip)

Telephone: () _____

Current living arrangements: Lives alone Lives with spouse
 Lives with relative or friend (please describe)
 Lives in another Healthcare setting (please describe)

6. Religious affiliation if any: _____

7. Current primary care physician: _____

(Address) Telephone: () _____

8. Does anyone assist the Applicant with the following? Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Transferring in and out of bed or chair |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Wandering <input type="checkbox"/> Coagulation therapy (Coumadin...) |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Memory issues <input type="checkbox"/> Insulin management |
| <input type="checkbox"/> Other significant issues: _____ | |

9. Medical conditions that have led to application to Healthcare Center or Personal Care: _____

10. Recent hospitalizations or surgeries: _____

11. Is Applicant currently receiving hospice services? yes no

Insurance Information:

Social Security Number: _____ Medicare Number: _____

Other Health Insurance or Coinsurance: _____
(Company) (Member number)

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Medical Assistance/ACCESS Number (if applicable): _____

Long Term Care Insurance Company (if applicable): _____
(Please attach the schedule of benefits)

Veteran status: yes no spouse/surviving spouse unknown

Please include copies (front and back) of all cards

Financial Information:

Note: This confidential document will be viewed as privileged information and secured in the Resident's business file. After admission, this Application Form will become part of the Admission Agreement.

ASSETS

Cash and Savings:

\$ _____
(Amount) (Bank) (Account owners)

\$ _____
(Amount) (Bank) (Account owners)

CDs, Stocks, Bonds, Mutual Funds, IRAs, 401Ks:

(Type) \$ (Amount) (Bank) (Account owners)

Real Estate:

(Address) \$ (Estimated Value) (Property owners)

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Life Insurance: Face Value: \$ _____ Cash Value: \$ _____ Owner: _____

Has Applicant sold (or transferred) Real Estate in the past 5 years (60 months)? yes no

Date(s) sold: _____ Amount received from sale(s): \$ _____

MONTHLY INCOME

Social Security: \$ _____ Company pension: \$ _____
Veteran pension: \$ _____ Government pension: \$ _____
Interest, dividends: \$ _____ Rental income: \$ _____
IRAs: \$ _____
Annuities: \$ _____ (Please provide detail: _____)
Other: \$ _____ (Please provide detail: _____)

LIABILITIES

Mortgage current balance: \$ _____ Car loan current balance: \$ _____
Credit card debt total amount: \$ _____ Other (Heloc, note...): \$ _____

TRANSFERS

Has Applicant transferred assets to a trust or similar financial instrument within the past 5 years (60 months)?

yes no If yes, please explain: _____

Has Applicant transferred any other assets within the past 5 years (60 months)? yes no

If yes, please explain: _____

FUNERAL ARRANGEMENTS

Has Applicant established a prepaid funeral and burial account? yes no

If so, is it irrevocable? yes no

Preferred funeral services provider: _____
(City)

Contact Information (Provide at least one)

#1 _____ Power of Attorney? yes no
(Name) (Relationship)

(Address) (Email)

(Home phone) (Cell phone) (Work phone)

#2 _____ Power of Attorney? yes no
(Name) (Relationship)

(Address) (Email)

(Home phone) (Cell phone) (Work phone)

Admissions are made without regard to age, race, color, religious creed, disability, national origin, or sex. For the health and safety of all, Cross Keys Village - The Brethren Home Community has a No Tobacco Policy.

- Applicant/POA hereby declares that all statements herein are true and complete to the best of our knowledge and belief, and that all assets and income listed are available to pay for Applicant's care.
- If approved for admission, Applicant/POA agrees not to dispose of assets or income at less than fair market value.
- Applicant/POA also agrees to report significant changes in assets, liabilities, or income to the Accounting Services Department.
- Applicant/POA agrees to provide additional information periodically as requested.

By signing below, the Applicant and/or Responsible Party acknowledges an understanding of and commitment to comply with the statements above. Any false information or misrepresentation of information or lack of disclosure in this Application may result in the rejection of this Application and/or the termination of the Admission Agreement.

Signature of Applicant/POA: _____ Date: _____

Person Completing Application (if different from above):

Signature: _____ Date: _____

Relationship to Applicant: _____

If you are mailing or faxing this application:

1. Please include copies (front & back) of Social Security Card, Medicare Card, and Health Insurance Cards including prescription and PACE if applicable.
2. Make sure the application is as complete as possible at this time. If you have questions or would like to schedule a tour, please call the appropriate service line representative:

Healthcare Center (Nursing) – Admissions Counselor: (717) 624-5513
Personal Care – Admissions Counselor: (717) 624-5436

3. Please remember to sign and date the application.
4. Upon receipt of application, you will receive notification from the appropriate service line representative.



Main switchboard: (717) 624-2161
Nursing Center Fax: (717) 624-5216
Personal Care Fax: (833) 983-2448

Mail to:
Nursing Admissions / Personal Care Admissions
2990 Carlisle Pike
New Oxford, PA 17350
www.crosskeysvillage.org

Date application was received: _____
 Application received by: _____