CROSS KEYS VILLAGE
The Brethren Home Community

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 HEALTH CARE 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:

- ☐ Short Term Nursing Care or Rehab
- ☐ Long Term Nursing Care
- ☐ Secure Dementia Nursing Care
- ☐ Long Term Personal Care
- ☐ 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 Health Care setting (please describe)
   ____
6. Religious affiliation if any: ____________________
7. Current primary care physician: ______________________________
   ______________________________ Telephone: (   ) ____________
   (Address)
8. Does anyone assist the Applicant with the following? Please check all that apply:
   - ☐ Bathing
   - ☐ Dressing
   - ☐ Toileting
   - ☐ Transferring in and out of bed or chair
   - ☐ Wandering
   - ☐ Memory issues
   - ☐ Coagulation therapy (Coumadin…)
   - ☐ Insulin management
   - ☐ Other significant issues: ______________________________

9. Medical conditions that have led to application to Health Care 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)

_________ $_____________________ ________________ ____________________________
(Type) (Amount) (Bank) (Account owners)

_________ $_____________________ ________________ ____________________________
(Type) (Amount) (Bank) (Account owners)

_________ $_____________________ ________________ ____________________________
(Type) (Amount) (Bank) (Account owners)

Real Estate:

__________________________ $________________ ________________________________
(Address) (Estimated Value) (Property owners)

__________________________ $________________ ________________________________
(Address) (Estimated Value) (Property owners)

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 their Representative acknowledge 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: ____

<u>If you are mailing or faxing this application</u>:

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:

   Health Care Center (Nursing) – Admissions Counselor: (717) 624-5250
   Personal Care – Marketing Specialist: (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: (717) 624-2241

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

Date application was received: _______________

Application received by: ______________________