3952 Columbia Avenue
West Hempfield Twp., PA 17512-9715
717-285-5443
www.stannesrc.org

APPLICATION FOR ADMISSION

This application is for: __Immediate Need __Future Need: __Months/Years

Applying for: __Apartments __Cottages __ Personal Care __ Personal Care Memory Support
__ Skilled Care __Skilled Care Memory Support

How did you hear about St. Anne's Retirement Community? ____________

Name: ____________ Social Security #: ____________

Address: ____________ Home Phone: ____________

Email: ____________ Cell Phone: ____________

Date of Birth: ____________ Place of Birth: ____________ Male: ____ Female: ____

Marital Status: ____________ Spouse's Name: ____________

Please circle the appropriate answer:

Do you have an Advance Directive/Living Will?	Yes	No
Do you have a Durable Power of Attorney (POA) for Health Care?	Yes	No
Do you have a Will?	Yes	No

If yes, who is the Executor? ____________

Power of Attorney's Name: ____________ Phone Number: ____________

Address: ____________

Email: ____________

Type of POA: Financial: ____ Medical: ____

Children/Significant Other (Please list individuals in the order they should be contacted if unable to reach POA)

Name: ____________ Relationship: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ____________ Email: ____________

Name: ____________ Relationship: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ____________ Email: ____________

Name: ____________ Relationship: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ____________ Email: ____________

Name: ____________ Relationship: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ____________ Email: ____________

To Be Admitted From (check one): ____ Residence ____ Hospital ____ Health Facility

If Hospital – Name and Unit: ____________

List Inpatient Stay Dates for Past Year (Hospital, Other Facility, Transitional Care, etc.): ____________

Long Term Goal

____ Return Home ____ Transfer to another Facility/Level of Living ____ Remain at St. Anne's

Primary Health Insurance (Medicare, Advantage Plan, PPO)

Insurance Company: ______________________

Policy/ID Number: ______________ Group Number (if applicable): ______________

Address: ____

Phone Number: ______________

If Health Insurance is Medicare:

Part A Effective Date: __________ Part B Effective Date: __________

Secondary Health Insurance

Carrier Name: ______________ Insured Name: ______________

Address: ____

Phone Number: ______________

Policy/ID #: ______________ Group Number (if applicable): ______________

Annual cost for insurance is: __________

Do you have Long Term Care Insurance? Yes: ____ No: ____

Policy # ________ Daily Personal Care Benefit ________ Daily Skilled Nursing Benefit ________

If Yes, Carrier ______________

Address: ____

Phone Number: ______________

Do you have Life Insurance? Yes: ____ No: ____

If Yes, Company ______________________

Face Value: __________ Cash Value: __________

Beneficiary: ______________________

Have you applied for Medical Assistance (MA): Yes: ____ No: ____

If Yes, when? ______________ MA #: ______________

Are you a veteran/spouse of a veteran: Yes: ____ No: ____

Branch of Service: ______________________

Do you take prescription medicines Yes: ____ No: ____ Average Monthly Cost is: __________

Do you receive medication from the VA? Yes: ____ No: ____

Do you have a prescription card? Yes: ____ No: ____ Type: ______________

Community Physician: ______________________ Phone Number: ______________

Church: ______________ Address: ______________________

Phone Number: ______________ ______________________

Clergy: ______________

Funeral Home: ______________ Address: ______________________

Phone Number: ______________ ______________________

Do you have a Burial Trust/Prepaid Funeral?: Yes: ____ No: ____

Financial Information

Have you, or your Power of Attorney, received financial planning services? ____ Yes ____ No

If yes, Name(s) of financial planning service employed by you, or your Power of Attorney____________________

Do you, or your Power of Attorney, have an attorney assisting you? ____Yes ____ No

If yes, Name of Attorney ____________________ Phone #____________________

Have you disposed of, or gifted, real estate or personal property within the last 5 years? Yes:____ No:____

If Yes, list date and explain:____________________

Please supply copies of your latest statement for the assets listed below. Please identify if the asset, liability or monthly income are joint or individual, by selecting I (individual) J (joint) or S (spouse) in the corresponding column. Please enter totals unless otherwise specified.

ASSETS		I	S	J
Cash				
Checking				
Savings				
Certificates of Deposit				
Individual Retirement Accounts, 401k				
Mutual Funds				
Annuities				
Stocks and Bonds				
Real Estate				
Trust Accounts				
Loans to Others				
Total Assets	$			

LIABILITIES		I	S	J
Rent				
Credit Card Debt				
Other Debts				
Mortgage Balance				
Total Liabilities	$			

Monthly Income		I	S	J
Social Security				
Pension				
Annuities				
Investment Income				
Rental Income				
VA Benefits				
Total Monthly Income	$			

Real Estate Owned

Street Address	City	State	Zip Code	Estimated Value	Mortgage Balance

Other Assets

Asset	Fair Market Value	Joint/Individual

I represent the resources listed above are and will remain avalable for payment of services I may receive at St. Anne's Retirement Community.

Have you ever been convicted of a crime other than a summary offense? Yes: ____ No: ____

If Yes, What was the Date of the Conviction? ____________________

If Yes, Please describe the Conviction: ____________________

____

AGREEMENT

I have applied for admission to St. Anne's Retirement Community. In doing so, I understand that St. Anne's Retirement Community has a special obligation to clients, Residents and staff with respect to their personal property and safety. I herby give St. Anne's Retirement Community the right to make a thorough investigation into my previous employment, education, references, and character, and I release from all liability all persons supplying such information. The investigation is not limited to the above, and criminal checks both–State and Federal–can be required. I authorize all public officials or persons involved in reference for admission to furnish information necessary for residency at St. Anne's Retirement Community. Records obtained will be confidential.

I hereby certify that the information and financial statements provided in this application are correct and complete to the best of my knowledge. I understand that any misrepresentation could result in the forfeiture of my application or status as a resident of St. Anne's Retirement Community, Inc. I understand that this application does not obligate St. Anne's Retirement Community, Inc., in any way and is submitted to be placed on file, and that the above information is strictly confidential.

In the event a resident becomes a danger to themselves and/or others, as in the judgment of the attending physician and Administrator, to jeopardize the health and/or safety of other residents or constitutes a hazard to himself/herself, St. Anne's Retirement Community shall cooperate with the relative or responsible party in finding the most appropriate placement for the Resident.

______________________________	______________________
Signature of Applicant/Responsible Party	Date
Signature of Administration	Date
Signature of Approval	Date of Approval