



APPLICATION FOR ADMISSION

This application is for: Immediate Need Future Need
Please check level of care: Health Care Personal Care Independent
How did you hear about St. Anne's Retirement Community? _____

Name: _____ S.S. No.: _____

Address: _____ Spouse's Name: _____

Phone Number: (____) _____ Birth Date: _____ Birth Place: _____

Bills to be paid by: _____ Phone: (____) _____

Address: _____ Power of Attorney (POA): Yes No

Medical POA if different than Financial: _____ Phone: (____) _____

Address: _____

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

Name	Address	Home #	Work #	Cell #

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.): _____

Please circle the appropriate answer:

- Do you have an Advance Directive for your Health Care? Yes No
- Do you have a Durable Power of Attorney for Health Care? Yes No
- Do you have a Living Will? Yes No
- Do you have a Will? Yes No

If yes, who is the Executor? _____

List present medical/physical/mental condition(s): _____

List past medical/physical/mental condition(s): _____

Insurance Information

Primary Health Insurance (i.e. Medicare): _____

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

Address: _____

Phone Number: _____

If Health Insurance is Medicare:

Part A Effective Date: _____ Part B Effective Date: _____

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

If yes, when?: _____

Secondary Health Insurance (i.e. HMO, PPO, BC, BS):

Carrier Name: _____ Insured Name: _____

Address: _____

Phone Number: _____

Policy/ID #: _____ Group # (if applicable): _____

Annual cost for insurance is: _____

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

If yes, Carrier _____

Address: _____

Phone Number: _____

Policy #: _____ ID#: _____ Group # (if applicable): _____

Do you take prescription medicines: Yes _____ No _____ Average monthly cost is: _____

Do you have a prescription card? Yes _____ No _____ Type: _____

Long Term Goal: _____ Return Home _____ Transfer to another Facility (PCH/Assisted Living)
_____ Remain at St. Anne's Retirement Community _____ Uncertain/Depends on Progress

Physician to be used at St. Anne's: _____ Phone Number: (____) _____

Address: _____

Community Physician if different from above: _____ Phone Number: (____) _____

Dentist: _____ Address: _____

Phone Number: (____) _____

Church: _____ Address: _____

Phone Number: (____) _____

Clergy: _____ Address: _____

Phone: (____) _____

Funeral Home: _____ Address: _____

Phone Number: (____) _____

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

If Yes, please list: _____

Financial Information

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

If Yes, to whom? _____

Are any assets in trust for your benefit? Yes: ____ No: ____

If Yes, Name and Address of trustee Name _____

Address: _____

Date Established: _____

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) or J (joint) in the corresponding column. Please enter totals only unless otherwise specified.

ASSETS			J/I	LIABILITIES			J/I
Cash	Checking	\$		Mortgages	\$		
	Savings			Line of Credit Outstanding			
Certificates of Deposit				Other Debts (please list)			
Individual Retirement Accounts							
Pension/Profit Sharing Accounts							
Annuities							
Stocks and Bonds							
Real Estate (provide address on page 4)							
Trust Accounts							
Cash Value of Life Insurance							
Other (please list on page 4)							
Total Assets		\$		Total Liabilities	\$		

MONTHLY INCOME		J/I
Social Security	\$	
Deferred Compensation		
Pensions and Annuities		
Investment Income		
Total Monthly Income	\$	

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

If yes, please list below

Life Insurance

Company	Face Value	Beneficiary

Real Estate Owned

Street Address	City	State	Zip Code	Estimated Value	Mortgage Balance

Other Assets

Asset	Fair Market Value	Joint/ Individual

AGREEMENT

I hereby certify that the above information, statements provided and the schedule on page 2 is 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 so mentally ill, as in the judgment of the attending physician and Administrator, to jeopardize the health of other residents or constitutes a hazard to himself/herself, St. Anne’s Retirement Community shall cooperate with relative or the responsible party in finding the most appropriate placement for the welfare of the mentally ill resident.

Signature of Applicant/Responsible Party

Date

Signature of Administration

Date

Thank you for considering St. Anne’s Retirement Community. If you have any questions, call the Admissions Coordinator at (717)285-1404.

ST ANNE’S RETIREMENT COMMUNITY WILL NOT ADMIT PERSONS WITH ACTIVE TB. IF A RESIDENT DEVELOPS ACTIVE TB, THEY WILL BE TRANSFERRED TO THE HOSPITAL OF THEIR CHOICE.