APPLICANT NAME:_____

LONDONDERRY VILLAGE

1200 GRUBB ROAD · PALMYRA PA 17078

PERSONAL CARE / NURSING CARE APPLICATION FOR ADM

DATE _____ REFERRED BY _____

APPLICATION FOR: PERSONAL CARE ..... ❑
NURSING CARE..... ❑

NAME OF APPLICANT _____

FIRST MIDDLE LAST (MAIDEN)

PRESENT ADDRESS _____

STREET / ROUTE TOWN / CITY STATE ZIP CODE

TELEPHONE NUMBER (____)_____ U.S. CITIZEN? ❑YES ❑NO IF NO, WHERE? _____

SOCIAL SECURITY # _____ - _____ - _____ MEDICARE #_____ MEDICAID # (IF APPLICABLE) _____

MEDICARE ADVANTAGE _____ ***ATTACH COPIES OF INSURANCE CARDS, FRONT & BACK SIDE**

DATE AND PLACE OF BIRTH _____

MARITAL STATUS: ❑SINGLE ❑MARRIED ❑WIDOWED ❑DIVORCED

VETERAN OF MILITARY SERVICE? ❑YES ❑NO

A. FULL NAME OF SPOUSE_____

B. AGE OF SPOUSE_____ C. DATE OF DEATH (IF WIDOWED) _____

HEALTH CARE POWER OF ATTORNEY:

NAME	ADDRESS	RELATIONSHIP	HOME/WORK/CELL PHONE
_____	_____	_____	_____
_____	_____	_____	_____

FINANCIAL POWER OF ATTORNEY:

NAME	ADDRESS	RELATIONSHIP	HOME/WORK/CELL PHONE
_____	_____	_____	_____

PERSON RESPONSIBLE FOR PAYMENT OF BILLS:

NAME	ADDRESS	RELATIONSHIP	HOME/WORK/CELL PHONE
_____	_____	_____	_____

HAS A LIVING WILL/ADVANCE DIRECTIVE BEEN EXECUTED? ❑YES ❑NO **IF YES, PLEASE ATTACH COPY OF DOCUMENT(S)**

APPLICANT NAME:_____

RELIGIOUS AFFILIATION: _____ HOSPITAL PREFERENCE:_____

NAME, ADDRESS AND TELEPHONE NUMBER OF PRIMARY PHYSICIAN:

NAME _____ PHONE NUMBER_____

STREET _____ CITY, STATE, ZIP CODE_____

CURRENT MEDICAL PROBLEMS/DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS BEING TAKEN:

_____

_____

_____

_____

_____

_____

_____

FUNERAL ARRANGEMENTS:

A. FUNERAL HOME PREFERRED _____

ADDRESS _____ TELEPHONE (_____) _____

B. SPECIFIC WRITTEN INSTRUCTIONS FOR AUTOPSY, DONATION OF ANY BODY PARTS, CREMATION, ETC.

❑YES ❑NO IF YES, WHO HAS THESE INSTRUCTIONS _____

C. NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON RESPONSIBLE FOR ARRANGEMENTS:

NAME(S)_____ TELEPHONE (_____) _____

ADDRESS _____ CITY, STATE, ZIP _____

PAST/PRESENT LIVING SITUATION: ❑LIVING ALONE ❑WITH SPOUSE ❑OTHER (NAME/RELATION) _____

HAVE YOU BEEN A RESIDENT IN ANY OTHER HOME/FACILITY/INSTITUTION IN THE LAST 60 DAYS? ❑YES ❑NO

IF YES, FROM _____ TO _____ NAME/ADDRESS OF FACILITY _____

APPLICANT NAME:_____

FINANCIAL STATEMENT

THIS FINANCIAL STATEMENT IS PART OF THE APPLICATION PROCESS AND MUST BE COMPLETED. INFORMATION WILL BE KEPT CONFIDENTIAL.

ASSETS

MONEY IN BANK OR ELSEWHERE (SAVINGS, CHECKING, CD'S TRUSTS, ANNUITIES, ETC…) PLEASE INDICATE IF **JOINT** ACCOUNT:

TYPE OF ACCOUNT:	CURRENT BALANCE ($):	NAME OF FINANCIAL INSTITUTION: JOINT ACCT. Y/N
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INVESTMENTS: CURRENT VALUE OF ALL STOCKS, BONDS, ETC. $ _____

CURRENT VALUE OF ANY RETIREMENT FUNDS (E.G. 401K) $ _____

LIFE INSURANCE:

COMPANY	POLICY NO.	OWNER	BENEFICIARY	CASH VALUE	FACE VALUE
_____					
_____					

REAL ESTATE - TOTAL VALUE OF ALL HOUSES, FARMS AND LOTS:

HOUSES, FARMS AND LOTS _____ LOCATION _____MARKET VALUE $_____

SOURCES OF INCOME

MONTHLY AMOUNT RECEIVED FOR:

SOCIAL SECURITY $ _____ MEDICAID $ _____ ANNUITIES $ _____

SSI $ _____ PENSION $ _____ OTHER $ _____

OTHER INFORMATION

DO YOU HAVE: PRIMARY HEALTH INSURANCE:_____

SUPPLEMENTAL INSURANCE: _____

LONG TERM CARE INSURANCE: _____

BURIAL FUND, IF YES, WHERE DEPOSITED_____ AMOUNT $_____

ANY ASSETS TRANSFERRED TO FAMILY OR AN ORGANIZATION IN THE LAST 5 YEARS? ❑YES ❑NO

IF YES, TO WHOM_____ WHEN_____ AMOUNT $ _____

***ATTACH ADDITIONAL FINANCIAL INFORMATION IF NECESSARY**

APPLICANT'S SIGNATURE / POA SIGNATURE: _____ DATE: _____