

APPLICATION FOR ADMISSION
GOLDEN RIDGE PERSONAL CARE HOME
404 South Church Street, Robesonia, PA 19551
Phone: 610-693-5850 Fax: 610-693-6871

Thank you for taking the time to answer all the questions as completely as possible. The contents of this application shall remain in the resident's folder and remain confidential.

This application must be completed in its entirety and returned to Golden Ridge to be considered for admission. Please print clearly. If you have any questions or need assistance with this application please feel free to contact Golden Ridge and ask for Lynn or Roxanne.

Name: Last _____ First _____ Middle _____

Date of birth: _____ Age: _____

Current living condition: _____

Address: _____

Phone number: _____

Social Security Number: _____

You will need to make copies of all insurance cards and attach to this application or bring them with so we can make copies.

Medicare Number: _____

Other Health Insurance: _____

Do you have a Pace or Pace Net card: Yes ___ / No ___ Pace _____ Pace Net _____

Marital Status: _____ Spouse's name _____

Do you have a Power of Attorney: Yes ___ / No ___ (financial, health, or both – please circle)

If yes, Name: _____ Relationship: _____
(Please include copy or bring with to copy)

Address: _____

Phone Number: _____

Do you have a Living Will: Yes ____ / No ____ **(If yes please include copy or bring with to make copy)**

Do you have your funeral arrangements made: Yes ____ / No ____

If yes, name of Funeral Home: _____

Address: _____

Phone number and contact person: _____

Have you pre-paid your funeral expenses: Yes ____ / No ____

Religious Affiliation: _____

Church: _____

Do you have any children: Yes ____ / No ____

If yes please list Name(s), address, and phone numbers:

Who referred you or how did you find out about Golden Ridge: _____

Family Physician: _____

Address: _____

Phone number: _____

Are you under the care of any specialists: Yes ____ / No ____

If yes, please list Name(s), Address and Phone Number(s): _____

Do you take any medications: Yes ____ / No ____

If yes, please list name, strength and how often (include prescription, supplements, herbal and over-the-counter medications)

Do you have any allergies: Yes ____ / No ____

If yes, please list and what reaction you have: _____

Do you smoke: Yes ____ / No ____ Do you drink alcohol: Yes ____ / No ____

Are you on a special diet: Yes ____ / No ____

If yes, please describe: _____

Describe any difficulty you have with seeing, hearing or communicating: _____

List any devices you need to help you see, hear, or communicate: _____

Do you have any difficulty walking: Yes ____ / No ____

List any devices you use to help you walk: _____

Do you need assistance with eating: Yes ____ / No ____

If yes, explain: _____

Do you need assistance with bathing: Yes ____ / No ____

If yes, explain: _____

Do you need assistance with dressing/undressing: Yes ____ / No ____

If yes, explain: _____

Do you need assistance with getting in and out of chairs or bed: Yes ____ / No ____

If yes, explain: _____

Do you have problems with your bowels or bladder or need assistance with going to the bathroom: Yes ____ / No ____

If yes, explain: _____

If you do have problems with your bowels or bladder do you wear special undergarments: Yes ____ / No ____

If yes, please list: _____

Do you wear dentures: Yes ____ / No ____ (uppers, lowers, or both - Please circle)

Do you experience forgetfulness: Yes ____ / No ____

If yes, explain: _____

Do you experience periods of confusion or disorientation: Yes ____ / No ____

If yes, explain: _____

Do you have any identifying marks, tattoos, or scars: Yes ____ / No ____

If yes, please list and where located: _____

Have you received the pneumovac vaccine to prevent pneumonia (this is not the same as the yearly flu vaccine): Yes ____ / No ____

If yes, on what date: _____

Do you receive the flu vaccine every year: Yes ____ / No ____

Beginning with the most recent, please list any hospitalizations along with the date, reason and which hospital: _____

What is your hospital preference? _____

Name of responsible party for applicant: _____

Relationship: _____

Address: _____

Phone number(s): _____

To whom should communication be directed regarding this application:

Name: _____

Address: _____

Phone Number: _____

Did the Applicant fill out or assist in filling out this application: Yes ____ / No ____

If no, please state your name and relationship to applicant: _____

Applicant's signature or mark

Date

Signature of person completing application for applicant

Date

FINANCIAL SHEET

DO YOU HAVE ANY OF THE FOLLOWING	YES	NO	AMOUNT	MONTH	YEAR
Cash on hand					
Savings accounts – including joint accounts					
Checking accounts – including joint accounts					
CD or Money markets					
Stocks or Bonds – including US Savings					
Notes – including Treasury					
Credit Union Account					
Trust Account					
Personal Real-estate owned (home, land, etc)					
Investment Real-estate					
Business ventures					
Loans and Notes receivable					
Life Insurance					
Long Term care Insurance					
Burial account or burial fund					
Automobiles (describe)					

DO YOU RECEIVE INCOME FROM ANY OF THE FOLLOWING

Wages, salaries, tips or self – employment					
Alimony or any other type of settlement					
Dividends or interest from stocks, bonds, CDs, etc					
Room and board, rental, or investment income					
Business venture income					
Public Assistance or Blind Pension					
Social Security income					
Social Security Disability income					
Supplemental Security income (SSI)					
Black Lung benefits					
Veterans Pension or benefits					
United Mine Workers or other benefits					
Workers Compensation or sick benefits					
Relative or someone else					
Loans or Notes Receivable					
Other Retirements or Pension or Insurance (specify)					
Other sources (specify)					

DO YOU HAVE EXPENSES FOR ANY OF THE FOLLOWING

Mortgage or rent payments					
Real-estate taxes					
Federal / State taxes					
Health insurance					
Life insurance					
Long Term Care insurance					
Medical expenses including medications					
Loans, Credit cards, etc					
List any other expenses					