

**APPLICATION FOR ADMISSION**  
**GOLDEN RIDGE ASSISTED LIVING, INC.**  
404 South Church Street, Robesonia, PA 19551  
610-693-5850

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.**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Other Health Insurance: \_\_\_\_\_

Do you have a Pace or Pace Net card? \_\_\_\_\_ 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: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Do you have a Living Will? Yes \_\_\_\_\_ No \_\_\_\_\_

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: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have any children? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your current living arrangement: \_\_\_\_\_

\_\_\_\_\_

Who referred you to Golden Ridge? \_\_\_\_\_

Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Are you under the care of any specialists? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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Do you take any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you on a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe:

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

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List any assistive devices you need for seeing, hearing, or communicating:

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Do you have any difficulty walking? Yes \_\_\_\_\_ No \_\_\_\_\_

List any assistive devices you use for walking: \_\_\_\_\_

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Do you need assistance with eating? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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Do you need assistance with bathing? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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Do you need assistance with dressing/undressing? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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

If yes, explain: \_\_\_\_\_

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Do you have problems with your bowels or bladder? 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: \_\_\_\_\_

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Do you experience periods of confusion or disorientation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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Have you ever received the pneumovac vaccine to prevent pneumonia? (This is not the same as the annual flu vaccine) Yes \_\_\_\_\_ NO \_\_\_\_\_

If yes, on what date? \_\_\_\_\_

Do you receive the flu vaccine every year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, do you want to get the vaccine yearly when it is given at Golden Ridge? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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What is your hospital preference? \_\_\_\_\_

Please list responsible party for applicant: \_\_\_\_\_

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To whom should communication be directed regarding this application?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Did the Applicant fill out this application? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please state name and relationship to applicant: \_\_\_\_\_

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Applicant's Signature or Mark

Date

Signature of Person Completing Application for Applicant

Date

FININCLE SHEET

DO YOU HAVE ANY OF THE FOLLOWING	YES	NO	AMOUNT
Cash on hand			
Savings accounts, including joint accounts			
Checking accounts, including joint accounts			
CD's or Money Markets			
Stocks or Bounds - 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, self-employment			
Alimony or any other sort of settlement			
Dividends, interest from stocks, bonds, CD's, etc			
Room and Board or 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			
Long Term Care insurance			
Life insurance			
Medical expenses including medications			
Loans, credit cards, etc			
List any other expenses (specify for month or year)			