4702 East Main Street
Belleville, PA 17004
Phone: (717) 935-2105 Fax: (717) 935-5109

ADMISSION APPLICATION

Valley View Haven (Nursing Care) _____	Memory Lane (Memory Care Unit) _____
Valley View Terrace (Personal Care) _____	Valley View Rehab _____

The information requested for on this form is needed to evaluate the applicant's request for admission. All information will be considered by the Admissions Committee and will be held in strict confidence. The acceptance of this form does not bind either party to admission. Failure to complete the application in its entirety could result in denial of consideration for admission. When two individuals apply together, a separate application must be completed for each one.

Valley View Haven (Nursing Care)	**Valley View Terrace (Personal Care)**
Private _______	A Style Suite _______
Semi-Private _______	B Style Suite _______
	C Style Suite _______
	Studio _______

I desire admission: Immediately: ______ At a later date ______ (*applicant must contact us in the future*)

Reason for seeking admission: ____

How did you learn of our retirement community? ______________________________

I. Demographics Section 1:

Applicant's Name: ____________________________________ ______ ______ Gender: ______
Last First Middle Title Suffix

Current Address: ____
Street Town State Zip Code

Telephone No.: _(______)_____________ Years at current address: ____________________

Marital Status: Single ______ Married ____________ Widowed ____________
Date Date

Divorced ____________ Separated ____________
Date Date

Date of Birth: _____________ Age: ______ Social Security No.: ________________________

II. Demographics Section 2:

Spouse's Name: ________________________ Telephone No.: _(______)_____________

Spouse's Address: ____
Street Town State Zip Code

Church Name: ____________________________ Religious Denomination: ____________________

Pastor's Name: ____________________________ Pastor's Telephone No.: _(______)_____________

Pastor's Address: ____
Street Town State Zip Code

Birthplace: _________________________________ Citizen of: ________________________________

Language: _________________________________ Maiden Name: _____________________________

Veteran? ______ Military Branch: ____________________ Years of Service ________________

Education (Highest): _________________ Former or Present Occupation: _________________________

List Your Current Hobbies, Talents, or Special Interests: ______________________________________

____

Prepaid Burial Reserve:

Name of Financial Institution: ____

Dollar Amount Reserved: __________________ Is the Agreement irrevocable? Yes ____ No ____

Funeral Home: ____ Telephone No.: ________________

Funeral Home Address:

____
Street Town State Zip Code

Living Will? Yes ____ No ____ *(Please provide copy upon admission)*

Exercise Right to Vote? Yes ____ No ____

II. Demographics Section 2 (Continued):

EMERGENCY CONTACTS:

First Contact (First person notified in case of an emergency):

Name: ______________________ Home Phone No.: ______________________
Address: ______________________ Work Phone No.: ______________________
Address: ______________________ Cell Phone No.: ______________________
Email address: ______________________
Relationship (e.g., Daughter/POA, Guardian): ______________________

Second Contact (Notified When the First Contact Cannot Be Reached):

Name: ______________________ Home Phone No.: ______________________
Address: ______________________ Work Phone No.: ______________________
Address: ______________________ Cell Phone No.: ______________________
Email address: ______________________
Relationship (e.g., Daughter/POA, Guardian): ______________________

Third Contact (Notified When the First & Second Contacts Cannot Be Reached):

Name: ______________________ Home Phone No.: ______________________
Address: ______________________ Work Phone No.: ______________________
Address: ______________________ Cell Phone No.: ______________________
Email address: ______________________
Relationship (e.g., Daughter/POA, Guardian): ______________________

OTHER CONTACTS:

Name: ______________________ Home Phone No.: ______________________
Address: ______________________ Work Phone No.: ______________________
Address: ______________________ Cell Phone No.: ______________________
Email address: ______________________
Relationship (e.g., Daughter/POA, Guardian): ______________________

III. Insurance Information:

1. Are you enrolled in Medicare? Yes ______ No ______ Medicare No.: _____________________

   Part A *(Hospitalization)*? Yes ______ No ______ Part B? Yes ______ No ______

2. Are you enrolled in a Medicare HMO? Yes ______ No ______

   Name of HMO ____ Phone: _(_____)________

   HMO Id. No.: ____________________ Primary Care Physician: _______________________

3. Do you have Medi-Gap Coverage *(for example, Blue Cross Security 65?)* Yes ______ No ______

   Name of Company: ____________________________ Insured's ID No.: ___________________

   Plan Type (circle one): A B C H Group No., if any: __________________

4. Do you receive Medical Assistance? Yes ____ No ____ County: _______________________

   Med. Assistance Recipient No.: ______________________ Expiration Date: _________________

5. Do you have other Health Insurance Coverage? Yes _____ No _____ Policy No.:______________

   Name of Company: _______________________________ Telephone: _(_____)_____________

6. Do you have Long Term Care Insurance? Yes _____ No _____ Policy No.:___________________

   Name of Company: _______________________________ Telephone: _(_____)_____________

IV. Financial Information (Please use whole dollar figures only):

A. Assets**:	Amount	Bank Name (*if bank account*)	Owners
Market Value of Real Estate*	$ ___________		
Checking Accounts	$ ___________		
Saving Accounts	$ ___________		
Certificates of Deposit	$ ___________		
Stocks & Bonds	$ ___________		
Mutual Funds	$ ___________		
Debts Others Owe to You	$ ___________		
Other: ___________________	$ ___________		
Other: ___________________	$ ___________		

* The market value of Real Estate is based on:____ Appraisal ____ Your Estimate

IV. Financial Information (Continued -Please use whole dollar figures only):

B. Liabilities**:	Amount	Bank Name (*if bank debt*)
Mortgages on Real Estate	$ ___________	____
Outstanding Loans or Notes	$ ___________	____
Other: ___________________	$ ___________	____
Other: ___________________	$ ___________	____
Other: ___________________	$ ___________	____

C. Monthly Income**:	Amount
Social Security	$ ___________
Pension or Retirement	$ ___________
Annuities	$ ___________
Interest & Dividends	$ ___________
Rental Income	$ ___________
Supplemental Security Income	$ ___________
Other: _______________________________	$ ___________
Other: _______________________________	$ ___________
Other: _______________________________	$ ___________

D. Have any of your assets been transferred to other individuals or organizations within the past five (5) years? Please note that a 'transfer' includes all gifts of real estate, vehicles, cash, or other items of value to organizations or individuals during any calendar month. The value of all gifts combined may not exceed $500 for any month. This would include gifts given to family members for holidays, birthdays, weddings, or any other occasion. Yes ______ No ______ If yes, please indicate what was transferred, who the resources were transferred to, and the value or amount transferred ***(please attach sheet)***.

***Supporting documentation (such as tax returns and/or bank statements) may be requested.*

V. Medical Information

A. Hospital and Physicians:

1. Hospital Preference:
   ______ Geisinger-Lewistown Hospital
   ______ J.C. Blair Memorial Hospital
   ______ Mount Nittany Medical Center

2. Ambulance Membership: ____

3. Physician's Name: ________________________________ Telephone: _(_____)___________
   Address: ____

V. Medical Information (Continued)

4. Dentist's Name: ________________________________ Telephone: _(_____)___________
   Address: ____

5. Ophthamologist's/
   Optometrist's Name: ______________________________ Telephone: _(_____)___________
   Address: ____

6. Podiatrist's Name: ________________________________ Telephone: _(_____)___________
   Address: ____

7. Other Physician/
   Specialist's Name: ________________________________ Telephone: _(_____)___________
   Address: ____

B. Diet

1. Please Check all that apply:

Regular	______	Ground	______
Diabetic	______	Soft	______
Low Sodium	______	Blended	______
Low Fat	______	Liquid	______
		Allergies	______

2. If Diabetic or Low Sodium, please explain: ________________________________
   ____

3. If there are Allergies, please explain: ____________________________________
   ____

4. Food Dislikes: ____
   ____

C. Physical Condition

1. Please check all that apply *(if you have questions, please check with your doctor)*:

______	Heart Trouble	______	High Blood Pressure
______	Tuberculosis	______	Alzheimer's Disease
______	Epilepsy	______	Senile Dementia
______	Cancer	______	Emphysema
______	Diabetes	______	Asthma
______	Contagious Disease	______	Glaucoma
______	Paralysis	______	Physical Deformity
______	Decubitus		

V. Medical Information (Continued)

2. If any of the above are checked, please explain ______________________________________

____

____

3. Describe in full, any illness, physical limitations or recent operations ___________________

____

____

4. Current Medications ____

____

5. List any Medications Allergies ____

____

6. Immunizations:

	Date Received	Name of Physician/Other Provider
Pneumococcal	____________	____________________________
Tetanus	____________	____________________________
Influenza	____________	____________________________

7. Most recent hospitalization:
   a. Dates: Beginning ____________________ Ending _____________________
   b. Hospital Name: ____
   c. Social Worker's Name: ____

8. Is the applicant currently receiving any Home Health Nursing or Rehabilitative Services?

   Yes _____ No _____ If yes, please explain __________________________________

   ____

9. Is the applicant currently using medical equipment? Yes _____ No _____

   If yes, describe ____

   Is Medicare Part B currently paying for this equipment? Yes _____ No _____

V. Medical Information (Continued)

10. History of Mental Illness? ? Yes _____ No _____

    If yes, describe ____

11. Has the applicant ever been hospitalized for mental illness?

    If yes, when and where? ____

12. Does the applicant smoke? Yes _____ No _____ If yes, how often? __________________

13. Does the applicant require any treatment relating to alcohol or drug addiction?

    Yes _____ No _____ If yes, please explain ____

    ____

VI. Activities of Daily Living and Personality:

A. Speech: Can be understood ____ Difficult to understand ____
Does not talk ____ Had therapy ____ Needs therapy ____

B. Hearing: Good ______ Impaired ______ Deaf ______ Hearing Aid ______

C. Sight: Good ______ Impaired ______ Blind ______ Glasses ______

D. Feeding: Independent ______ Needs Help ______ Must be fed ______
Nasal Tube ______ Gastro Tube ______

E. Bladder: Continent ______ Occasional Incontinence ______
Incontinent *(no control)* ______ Catheter ______
Ostomy, please specify ___________________________________

F. Bowels: Continent ______ Occasional Incontinence ______
Incontinent ______ Ostomy, please specify ____________________

G. Ambulation: Alone ______ With 1 person assisting ______
With 2 persons assisting ______ Bed to chair _____ Bed bound ______

H. Locomotion: Independent ____ Cane ____ Walker ____ Wheelchair ____ Geri-chair ______

I. Prosthesis: *(Please specify)*____

VI. Activities of Daily Living and Personality (Continued):

J.	Dental:	Dentures ______ Own Teeth ______	Partial Dentures ______ Other ________________________________
K.	Grooming:	Independent ______	Needs Assistance ______ Total Care ______
L.	Dressing:	Independent ______	Needs Assistance ______ Total Care ______
M.	Height ___________		Weight ___________
N.	Oriented:	Always ______	Confused at times ______ Always Confused ______
O.	Decision Making:	Independent ______ Unable to make decisions ______	Needs Assistance _______
P.	Alert:	Aware of surroundings ______	Sleeps Often ______ Comatose ______
Q.	Conversation:	Talkative ______	Normal ______ Quiet ______
R.	Emotional:		

1.	Usually has a positive attitude	____	Tends to have a negative attitude	____
2.	Tends to be withdrawn	____	Is usually interested in others	____
3.	Is usually confident	____	Tends to be fearful	____
4.	Is irritable and depressed at times	____	Tends to be pleasant and happy	____
5.	Is usually realistic	____	Tends to imagine things	____
6.	Can be defensive	____	Is usually easy going	____
7.	Usually has a good memory	____	Tends to be forgetful	____

I understand that Valley View Retirement Community retains the right to accept or reject any application consistent with the law. I certify that all of the information submitted on this application is true and correct, and I understand the submission of false information may constitute grounds for rejection of this application or my discharge after admission.

____________________ ____

Date Signature of Applicant or Responsible Party

05/2017