



214 Peach Orchard Road, McConnellsburg, PA 17233
717-485-3155

Long Term Care Application

Name _____ Date of Birth _____ Age _____
Address _____ Phone _____
Township: _____ County _____ Birthplace _____
Marital Status: M W S D Sex: Male Female Social Security # _____

POWER OF ATTORNEY _____

**Copy needed*

NAME

RELATIONSHIP

ADDRESS

PHONE

POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE MEDICAL DECISIONS YES NO
POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE FINANCIAL DECISIONS YES NO
DOES APPLICANT HAVE A LIVING WILL? *If yes, please provide us a copy. YES NO

Two (2) persons to contact in case of emergency other than POA:

NAME	RELATIONSHIP
ADDRESS	
HOME PHONE	OTHER PHONE

NAME	RELATIONSHIP
ADDRESS	
HOME PHONE	OTHER PHONE

List other relatives/special friends who may receive medical information.:

PHYSICIAN _____
NAME ADDRESS PHONE

DENTIST _____
NAME ADDRESS PHONE

OPTOMETRIST _____
NAME ADDRESS PHONE

CLERGY & CHURCH _____
NAME ADDRESS PHONE

FUNERAL DIRECTOR _____
NAME ADDRESS PHONE

BURIAL PLOT/CEMETARY?

IS YOUR BURIAL PREPAID?

WHO WILL BE RESPONSIBLE FOR YOUR ESTATE?

Social Information

WHAT ARE PRESENT LIVING ARRANGEMENTS? _____

WHY DO YOU NEED LONG TERM CARE AT THIS TIME? _____

LENGTH OF STAY? Short Term (LESS THAN 6 MONTHS) Long Term GREATER THAN 6 MONTHS)

If SHORT TERM, WHAT ARRANGEMENTS WILL YOU HAVE UPON DISCHARGE?

HOME RELATIVE'S HOME PERSONAL CARE HOME OTHER _____

DO YOU RECEIVE HOME HEALTH SERVICES? Yes No

If YES, SPECIFY: _____

DO YOU RECEIVE PRIVATE DUTY SERVICES? Yes No

If YES, SPECIFY: _____

DO YOU RECEIVE SERVICES FROM AREA AGENCY ON AGING? Yes No

If YES, SPECIFY: _____

DO YOU OWN/RENT YOUR EQUIPMENT? YES NO

WHEELCHAIR: OWN RENT FROM _____

HOSPITAL BED: OWN RENT FROM _____

WALKER: OWN RENT FROM _____

BEDSIDE COMMUNE: OWN RENT FROM _____

CANES OWN RENT FROM _____

OTHER: _____

WHO WILL PROVIDE TRANSPORTATION TO OUTSIDE MEDICAL APPOINTMENTS? _____

HIGHEST LEVEL OF EDUCATION/SCHOOLS ATTENDED _____

LIFETIME OCCUPATION _____

WORK SCHEDULE: _____

HOBBIES/INTERESTS _____

WHAT RECREATIONAL ACTIVITY WOULD YOU LIKE TO PURSUE DURING YOUR STAY? _____

DO YOU HAVE PETS? YES NO IF YES, SPECIFY _____

PERSONAL HABITS: SMOKER CHEWING TOBACCO ALCOHOL USE OTHER _____

Describe Daily Routine (eating, sleeping, bathing, etc...) _____

Medical Information

CURRENT DIAGNOSIS:

ALLERGIES? Yes No IF YES, SPECIFY _____

VACINATIONS:

Seasonal Flu- Date: _____

H1N1- Date: _____

Pneumonia- Date: _____

Tetanus- Date: _____

***PLEASE ATTACH LIST OF CURRENT MEDICATIONS.

DATE OF LAST OFFICE PHYSICIAN VISIT _____

REASON: _____

OTHER NURSING HOME ADMISSIONS (SPECIFY DATES): _____

MOST RECENT HOSPITALIZATIONS

HOSPITAL	REASON	DATES
1. _____		
2. _____		
3. _____		

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSIS?

- CANCER
- SCHIZOPHRENIA
- PANIC/ANXIETY
- QUADRIPLÉGIA
- FRACTURE
- SUICIDE
- AUTISM
- PSYCHOTIC DISORDER NOS
- STROKE
- DRUG ABUSE
- ENCEPHALITIS
- PERSONALITY DISORDER
- TUBERCULOSIS
- ALCOHOL ABUSE
- SPINA BIFIDA
- BLINDNESS & DEAFNESS
- HYPERTENSION
- CEREBRAL PALSY
- HYDROCEPHALUS
- TOURETTES'S SYNDROME
- MENINGITIS
- POLIO
- MULTIPLE SCLEROSIS
- ANOXIC BRAIN DAMAGE
- HEAD INJURIES
- BI-POLAR
- DEPRESSION
- EPILEPSY/SEIZURES
- DELUSIONS
- PARANOIA
- PARAPLEGIA
- SOMATOFORM DISORDER

ANOTHER MENTAL HEALTH DISORDER THAT MAY LEAD TO CHRONIC DISABILITY

MENTAL RETARDATION:

Services received: _____

OTHER INJURIES: _____

PSYCHIATRIC HOSPITALIZATION: _____ facilities and dates

SUICIDE ATTEMPTS: _____ Date of attempts

Nursing Needs

AMBULATION: WALKS ALONE WALKS WITH ASSISTANCE BED TO CHAIR ONLY NON-AMBULATORY

FALL HISTORY: Past 30 days Past 2-6 months Fracture within past 6 months

PATIENT AIDS: WALKER WHEELCHAIR CANE BRACE CRUTCHES OTHER _____

ORIENTATION: ORIENTED: PERSON PLACE TIME SITUATION SOMETIMES CONFUSED ALWAYS CONFUSED

COMMUNICATION: VERBAL NON VERBAL GESTURES SIGN LANGUAGE OTHER LANG. SPOKEN: _____

BEHAVIOR: WELL ADJUSTED DEPRESSED COOPERATIVE HOSTILE COMBATIVE WITHDRAWN
 WANDERS OTHER: _____

BOWEL/BLADDER: USES BATHROOM ALONE NEEDS HELP CATHETER
 COLOSTOMY INCONTINENT OF URINE INCONTINENT OF FECES
 OCCASIONAL INCONTINENCE USES BEDPAN USES BEDSIDE COMMUNE
 CONSTIPATION LAXATIVE TAKEN AT HOME

SKIN: OPEN AREAS RED AREAS ANY SPECIAL PROBLEMS? _____

DRESSING: DRESSES SELF DRESSES WITH SUPERVISION MUST BE DRESSED

List specifics: _____

BATHING: BATHES SELF BATHES WITH HELP TUB SHOWER COMPLETE BED BATH
Time of Day: _____ How often: _____

SLEEP SCHEDULE: Awakens at: _____ Retires at: _____ Other sleep habits: _____

EYESIGHT: NORMAL GLASSES BLIND NEED LARGE PRINT

HEARING: NORMAL HARD OF HEARING DEAF RIGHT EAR DEAF LEFT EAR HEARING AIDS

DENTATION: OWN TEETH UPPER DENTURES LOWER DENTURES

DIET: REGULAR DIET SPECIAL DIET POOR APPETITE FEEDS SELF MUST BE FED
 REQUIRES HELP TUBE FEED OTHER: _____

FOOD PREFERENCES _____ FOOD INTOLERANCES _____

Financial

(MUST BE COMPLETED OR APPLICATION WILL NOT BE PLACED IN RESOURCE POOLE.)

PRESENT INCOME	MONTHLY VALUE
<input type="checkbox"/> SOCIAL SECURITY-----	\$ _____
<input type="checkbox"/> SUPPLEMENTAL SECURITY INCOME-----	\$ _____
<input type="checkbox"/> PRIVATE PENSIONS _____	\$ _____
<input type="checkbox"/> INTEREST INCOME _____	\$ _____
<input type="checkbox"/> OTHER _____	\$ _____

Financial Assets

<input type="checkbox"/> BANK CHECKING ACCOUNT _____	\$ _____
<input type="checkbox"/> BANK SAVINGS ACCOUNT _____	\$ _____
<input type="checkbox"/> REAL ESTATE _____	\$ _____
<input type="checkbox"/> SAVINGS BONDS, STOCKS, CERTIFICATES _____	\$ _____
<input type="checkbox"/> OTHER _____	\$ _____

HAVE ANY ASSETS BEEN TRANSFERRED IN THE PAST (FIVE) YEARS? YES NO

If yes, give description of transfer and provide date: _____

WHO WILL RECEIVE BILLING AND FINANCIAL INFORMATION? _____

Insurance Information

MEDICARE # _____ HOSPITAL (PART A) Date: _____ MEDICAL (PART B) Date: _____

SECONDARY INSURANCE: _____ CONTRACT # _____ GROUP # _____

MEDICAL ASSISTANCE # _____

PACE PRESCRIPTION PLAN: _____ Member ID: _____ RxBIN: _____ RxPCN: _____ RxGrp: _____

CURRENT PHARMACY: _____ PHONE # _____

LONG TERM CARE INSURANCE: NAME OF POLICY _____ POLICY # _____

LIFE INSURANCE:

NAME _____ POLICY # _____ DATE ACQUIRED: _____ FACE VALUE: _____ CASH VALUE: _____

NAME _____ POLICY # _____ DATE ACQUIRED: _____ FACE VALUE: _____ CASH VALUE: _____

BURIAL ASSOCIATIONS

SIGNATURE OF PERSON COMPLETING APPLICATION _____ DATE: _____

ADDRESS _____ PHONE _____ RELATIONSHIP TO APPLICANT _____

WHO SHOULD BE CONTACTED FOR ADMISSION? _____