Rev 10.15

# Pre-Admission Application

99 Barclay Street Newtown, PA 18940 267-291-2300 FAX 267-291-2301

This is not an agreement and is issued for information only. PLEASE PRINT.

## PERSONAL INFORMATION

**DATE:**________________

**POTENTIAL RESIDENT (Circle: Male Female )**

Name ________________________________________
Last First Middle

Nickname: _________

**Legal Home ADDRESS:** ____________________________________

City __________________________ State _________ Zip ________

Telephone Number (______)____________________

Birth Date ____/_____/______ Hair Color _________ Eye Color __________
month day year

Social Security _______ - ______ - ________ **Medicare #**__________________

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Year Widowed: ____________

Areas Interested in:
- ☐ Adult Day Health Program
- ☐ Community Living
- ☐ Hicks Personal Care
- ☐ Friends Nursing Home
- ☐ Respite
- ☐ Residential Apartments
- ☐ Cottages/Lofts

**PRIMARY INSURANCE: Check One ☐ Medicare ; ☐ Other**

**If Other, Name**__________________________________ **Policy #** ____________________ **Group #** ____________

**Telephone #** __________________________ **Subscriber** __________________________________

**SECONDARY INSURANCE: Name** __________________________ **Policy #** __________________ **Group #** ____________

**Telephone #** __________________________ **Subscriber** __________________________________

Have Advance Directives/Living Will been completed? ☐ YES ☐ NO

Has a durable medical power of attorney been designated? ☐ YES ☐ NO

Name ___________________________________________________________ Telephone # ______________________

Has a durable financial power of attorney been designated? ☐ YES ☐ NO

Name ___________________________________________________________ Telephone # ______________________

**Current Physician:** ________________________________________________**Telephone #** ________________________

**Hospital Preferred:** _________________________________________________________________________

**Most Recent Hospitalization:** ___________________ ___________________________________________________
**Date** **Place**

_________________________________________________________________________
**Reason**

**How did you hear about Chandler Hall? ☐ Hospital ☐ Physician ☐ Word of Mouth ☐ Live Locally ☐ Social Worker**

**☐ Other Chandler Hall Program, please list:**____________________ **☐ Newspaper, please list:**_____________________

**☐ Other, please list:** ______________________________________________________________________________

**EMERGENCY INFORMATION:** **(Please Print)** **List two people to notify in case of emergency.**

**Name** ____________________**Relation**__________ **Name** ____________________**Relation**__________

**Address** ______________________________ **Address**______________________________

______________________________ ______________________________

**Home Phone #** ________________**Work**__________ **Home Phone #** ________________**Work**__________

**Cell Phone #:** ______________________________ **Cell Phone #** ______________________________

**Email:** ______________________________ **Email:** ______________________________

(Optional)
Religion/Affiliation: ______________________________ Place of Worship: ______________________________

Pastor/Rabbi: ______________________________ Telephone Number: (_____) ______________________

**LIVING ARRANGEMENT PRIOR TO ADMISSION:** ☐**Home Alone** ☐**Home Alone with Caregiver** ☐**Home with Home Health** ☐**Home with Family** ☐**Assisted Living/Personal Care Home** ☐**Nursing Home** ☐**Home and attending Adult Day Program** ☐**Home and attending Senior Center** ☐**Other(Explain)** ______________________________

**PERSONAL HISTORY**
**Reason for coming to Chandler Hall (your expectations):**

______________________________

______________________________

______________________________

**Life Review:** **Where Born/Raised:** ______________________________ **Marriage History:** ______________________________

**Children:** ______________________________ **Grandchildren:** ______________________________

**Work/Occupation:** ______________________________

**Education:** ☐**Less than 12** ☐**High School Graduate** ☐**Some College** ☐**College Graduate** ☐**Post Graduate** ☐**Unknown**

**Life interests/Accomplishments/Special life events:** ______________________________

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**RECREATION:** **(Check Preferences)**
☐**Cards/Other Games** ☐**Crafts/Arts** ☐**Exercise/Sports** ☐**Music**
☐**Reading/Writing** ☐**Nature** ☐**Gardening**
☐**Houskeeping/Cooking** ☐**Needlework/Sewing** ☐**Trips/Shopping**
☐**Spiritual/Religious Activities** ☐**Photography** ☐**Watching TV**
☐**Walking/Wheeling Outdoors** ☐**Collections** ☐**Travel**
☐**Other:** ______________________________

**If pre planned Funeral arrangements have been made please complete:**

**Name of Funeral Home:** ______________________________ **Phone** ________________

**Address:** ____________________**City** ________________**State** ________ **Zip** ________

**If pre planned Funeral arrangements have not been made, who would make arrangements?**________________

## HEALTH REVIEW

*Cottage, Loft or The Residences at Llenroc* applicants: Admission is not based on completing this optional page. Those applying for Adult Day Health Program should skip this page.

**All other applicants**: Please check to indicate recent problems in any of the following areas.

**HEAD AND NECK:**

☐ Headaches ☐ Sinus disease ☐ Enlarged glands ☐ Skin disease ☐ Ear disease ☐ Hearing Impairment ☐ Hearing Aid

☐ Eye disease ☐ Impaired vision Date last eye exam: ________________________ Other: ______________________________

**RESPIRATORY:**

☐ Cough ☐ Shortness of breath ☐ Sputum ☐ Hemoptysis ☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pneumonia

☐ Tuberculosis ☐ Pleurisy ☐ Other: _____________________________________

**CARDIAC:**

☐ Heart trouble ☐ High blood pressure ☐ Rheumatic fever ☐ Heart Murmurs ☐ Dyspnea ☐ Orthopnea ☐ PND

☐ Edema ☐ Chest Pain ☐ Palpitations ☐ Past EKG or other heart tests Other: __________________________________

**GASTROINTESTINAL:**

Appetite:____________ ☐ Weight gain/loss ☐ Difficult swallowing ☐ Nausea ☐ Vomiting ☐ Indigestion ☐ Abdominal pain

☐ Diarrhea Constipation ☐ Laxative use: _________________________________ ☐ Change in bowel habits ☐ Rectal bleeding

☐ Hemorrhoids Hernia ☐ Special diet: __________________________________ Other: _____________________________________

**GENITOURNIARY:**

☐ Difficulty ☐ Nightime urination(times per night): ____ ☐ Leaking of urine ☐ Blood in urine ☐ Painful urination ☐ Sexual function problems:

**Women:** ☐ Vaginal discharge or irritation ☐ Last Pap test: ____ Age at Menopause ____ Last Mammogram: ____ Number of Pregnancies: ___

**Men**: ☐ Prostrate trouble ☐ Discharge from penis Other: ______________________________________

**EXTREMETIES:**

☐ Joint or back pain ☐ Stiffness ☐ Arthritis ☐ Swelling ☐ Leg Pain ☐ Rash problems ☐ Skin Problems ☐ Cramping

☐ Varicose veins ☐ Blood Clots ☐ Other: __________________________________________

**NEUROLOGICAL:**

☐ Weakness ☐ Fatigue ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Balance trouble ☐ Falls ☐ Tremors ☐ Shakiness

☐ Fainting spells ☐ Nervousness ☐ Tension ☐ Mood ☐ Depression ☐ Forgetfulness ☐ Disruptive Behavior ☐ Wandering

☐ Other: _____________________________________________________

**HEMATOLOGIC:**

☐ Anemia ☐ Easy bruising ☐ Bleeding ☐ Past transfusions, Last Date: ____________________ ☐ Blood thinning medications

☐ Other: ____________________________________________

**ENDOCRINE:**

☐ Thyroid trouble ☐ Heat or cold intolerance ☐ Excessive sweating ☐ Diabetes ☐ Excessive thirst ☐ Hunger ☐ Urination

☐ Other: ____________________________________________

*Cottage, Loft or The Residences at Llenroc* applicants: Admission is not based on completing this optional page; however, do complete the signature box at the bottom of the page.

LIST OF CURRENT MEDICATIONS

| Medication Name | Dosage (Strength) | Frequency (Times Per Day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

HABITS: **Smoking:** ☐Currently, how much: ________________ ☐Past, when stopped: _____________ ☐Never

**Alcohol Use:** ☐Regularly ☐Occasionally ☐Rarely ☐Never

**Caffeine:** ☐Regularly ☐Occasionally ☐Rarely ☐Never

**Exercise:** ☐Regularly ☐Occasionally ☐Rarely ☐Never

**Insomnia:** ☐Regularly ☐Occasionally ☐Rarely ☐Never

**OPERATIONS/ADULT ILLNESS:**
**Describe Medical History/Diagnoses:**_______________________________________________

_______________________________________________

**INJURIES:** **Fractures** ______________________________ **Other:** ____________________

**VACCINATIONS:** **Last Flu vaccination:** ____________ **Pneumovax:** ______________ **Last Tetanus Booster:** ________

**ALLERGIES to medications, x-ray dyes, insect bites, food, or other substances, please list:** ____________________

**OTHER:** ☐**Able to feed self** ☐**Able to feed self if cued or food is cut and prepared** ☐**Able to dress self**

☐**Potential resident is continent** ☐**Able to walk independently** ☐**Memory Trouble: (for _____ months)**

Thank you for completing this application. There is no fee to submit this application to Chandler Hall.
Please return this application to Chandler Hall by drop off, mail, fax or email (admissions@ch.kendal.org).

Date__________________________ Signature of Applicant: ______________________________________

If applicant is unable to sign, signature of Responsible Party: ______________________________________

Relationship to Applicant: ______________________________ Date: ________________________

Chandler Hall services do not include guaranteed life care as reflected by Fee Schedules. Schedules are available upon request. Transfers between levels of care are on a space-available basis and subject to approved assessment.

Chandler Hall Health Services, Inc. a private, non-profit organization, does not discriminate on the basis of race, color, age, sex, religious creed, ancestry, national origin, sexual orientation, gender identity, disability, marital status, handicap, stance on advance directives or any other protected status.

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# FINANCIAL INFORMATION

Name ______________________________ Date: ______________

Marital Status: ☐Single ☐Separated ☐Married ☐Divorced ☐Widowed

## ASSETS

**Name of Bank** ______________ Balance $ ______________ Account: ☐Single ☐Joint
If joint, list other names ______________________________

**Name of Bank** ______________ Balance $ ______________ Account: ☐Single ☐Joint
If joint, list other names ______________________________

**Stocks & Bonds** If yes, list current holdings ______________ $ ______________ Account: ☐Single ☐Joint
______________ $ ______________ Account: ☐Single ☐Joint
______________ $ ______________ Account: ☐Single ☐Joint

**Real Estate** ______________ $ ______________ Ownership: ☐Single ☐Joint
If joint, list other names ______________________________
Is Real Estate currently on market? ☐Yes ☐No Has it been appraised? ☐Yes ☐No
Current Occupant/Relationship ______________________________

**Real Estate** ______________ $ ______________ Ownership: ☐Single ☐Joint
If joint, list other names ______________________________
Is Real Estate currently on market? ☐Yes ☐No Has it been appraised? ☐Yes ☐No
Current Occupant/Relationship ______________________________

**Other Assets** (please describe nature of other assets and whether ownership is single or joint:

______________________________ $______________

(Use additional paper to list any additional assets)

**Total Assets: $** ______________

## LIABILITIES

Please describe nature of any liabilities: ______________________________ $______________

______________________________

**Total Liabilities: $** ______________

## INCOME (Monthly or Monthly average of regular income)

Social Security $ ______________ Annuities $ ______________ Pension $ ______________

Interest Dividends $ ______________ VA Benefit or Other $ ______________ Other $ ______________

Long Term Care Insurance: Circle one: Yes No **Total Monthly Income: $** ______________

How do you expect to pay for care now? ______________________________
In three years? ______________________________

How do you expect to pay for changes in level of care/needs? ______________________________

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I confirm that the above information is complete and correct.

______________________________ ______________________________
Signature of Applicant/Date Signature of Person Completing Form for Applicant/Date

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______________________________
Resident

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PLEASE CHECK ALL THAT APPLY IN THE PAST YEAR

**VISION** (Ability to see in adequate light and with glasses if used)

- ☐ ADEQUATE - sees fine detail, including regular print in newspapers/books
- ☐ IMPAIRED - sees large print, but not regular print in newspapers/books
- ☐ MODERATELY IMPAIRED - limited vision; not able to see newspaper headlines, but can identify objects
- ☐ HIGHLY IMPAIRED - object identification in question, but eyes appear to follow objects
- ☐ SEVERELY IMPAIRED - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

**VISUAL APPLIANCES** (Does resident wear glasses or contacts?)

☐ No ☐ Yes

**HEARING** (With hearing appliance, if used)

- ☐ HEARS ADEQUATELY - normal talk, TV, phone
- ☐ MINIMAL DIFFICULTY - when not in quiet setting
- ☐ HEARS IN SPECIAL SITUATIONS ONLY - speaker has to adjust tonal quality and speak distinctly
- ☐ HIGHLY IMPAIRED - absence of useful hearing

**COMMUNICATION DEVICES TECHNIQUES**

- ☐ Hearing aid, present and used
- ☐ Hearing aid, present and not used regularly
- ☐ Other receptive communication techniques used (e.g., lip reading)
- ☐ NONE OF THE ABOVE

**CUSTOMARY ROUTINE CYCLE OF DAILY EVENTS**

- ☐ Stays up late at night (e.g., after 9 p.m.)
- ☐ Naps regularly during day (at least 1 hour)
- ☐ Goes out 1+ days per week
- ☐ Stays busy with hobbies, reading, or fixed daily routine
- ☐ Spends most of time alone or watching TV
- ☐ Moves independently indoors (with appliances, if used)
- ☐ Use of tobacco products at least daily
- ☐ NONE OF THE ABOVE

**ACTIVITY OF DAILY LIVING (ADL) PATTERNS**

- ☐ In bedclothes much of day
- ☐ Wakens to toilet all or most nights
- ☐ Has irregular bowel movement pattern
- ☐ Showers for bathing
- ☐ Bathing in PM
- ☐ NONE OF THE ABOVE

**INVOLVEMENT PATTERNS**

- ☐ Daily contact with relatives/close friends
- ☐ Usually attends church, temple, synagogue (etc.)
- ☐ Finds strength in faith
- ☐ Daily animal companion/presence
- ☐ Involved in group activities
- ☐ NONE OF THE ABOVE

**EATING PATTERNS**

- ☐ Distinct food preferences
- ☐ Eats between meals all or most days
- ☐ Use of alcoholic beverage(s) at least weekly
- ☐ NONE OF THE ABOVE

______________________________ Person Completing Form

______________________________ Relationship

______________________________ Date