



Mildred Shor InnSM
 OF THE MADLYN AND LEONARD
 ABRAMSON CENTER FOR JEWISH LIFE
 CARING FOR GENERATIONS

APPLICATION FOR MOVE-IN

Madlyn and Leonard
 Abramson Center for Jewish Life
 1425 Horsham Road • North Wales, PA 19454-1320
 Telephone 215-371-2103 Fax 215-371-3030
 www.abramsoncenter.org

RESIDENT INFORMATION

Name

Last

First

Middle Initial

Address

City

State

Zip

Telephone

Previous Address

City

State

Zip

From

To

Sex Male Female

Date of Birth ____/____/____

Age ____

Birthplace

Social Security #

Education

Veteran Yes No

Former Occupation

Marital Status Single Married Widowed Divorced Significant Other

Number of Children

Number of Grandchildren

Number of Great Grandchildren

Hebrew Name

Parents' Hebrew Names

How did you hear about the Mildred Shor Inn?

Friend

(name)

Center Program

(name)

Board Member

(name)

Organization

(name)

Social Worker

(name)

Internet

Other

(name)

Through joint programming, the Abramson Center develops and maintains relationships with a variety of Jewish communal organizations and synagogues. The programs are essential to building Jewish continuity and strengthening the connection for our residents with the community-at-large.

Please take a moment to tell us about the applicant's prior associations.

Is the applicant a current or former member of any of the following organizations?

- Hadassah Unit _____ Brith Sholom ORT B'nai Brith
 National Council of Jewish Women Jewish War Veterans Other _____

Congregation _____ Activities _____

Do you grant permission for us to notify the synagogue and/or organization upon move-in? Yes No

INSURANCE

Medicare # _____ Effective Date - Part A _____ Part B _____

Name of Supplemental Health Insurance Company _____

ID # _____ Group _____

Address for Claims Submission _____

HMO _____ ID# _____ Primary Care Physician _____

Private Long Term Care Insurance *Please attach a copy of the policy*

Company Name _____ Policy # _____

Address _____

Has the applicant appointed the following?

Power of Attorney – *Financial* NO YES ***Please include copy***
Name _____

Power of Attorney – *Health Care* NO YES ***Please include copy***
Name _____

Does the applicant have a *Living Will* or other medical directive? NO YES ***Please include copy***

Funeral/Burial Arrangements

Have funeral arrangements been made? NO YES

Funeral Home _____ Cemetery _____

Special Instructions _____

FINANCIAL DISCLOSURE*All information provided will be held in strict confidence.*

In order to process your application, please include copies of the most recent account statements for the items below.

INCOME

Social Security	Gross Amount per Month	\$ _____
Pension(Specify Type)_____	Gross Amount per Month	\$ _____
Disability(Specify Type)_____	Gross Amount per Month	\$ _____
Interest, Rentals, Dividends	Gross Amount per Month	\$ _____
Other Income(Specify)_____	Gross Amount per Month	\$ _____
TOTAL MONTHLY INCOME		\$ _____

ASSETS

	Institution	Account #	
Savings Account	_____	_____	\$ _____
Checking Account	_____	_____	\$ _____
Certificates	_____	_____	\$ _____
Stocks	_____	_____	\$ _____
Bonds	_____	_____	\$ _____
Mutual Funds	_____	_____	\$ _____
Trust Funds	_____	_____	\$ _____
Retirement Accounts	_____	_____	\$ _____
Real Estate Attach Copy of Deed	_____	_____	\$ _____
Other Resources Please Specify	_____	_____	\$ _____
TOTAL ASSETS			\$ _____

LIABILITIES

	Description	Payable to Bank, Person, etc.	Amount per Month
Mortgage	_____	_____	\$ _____
Loans	_____	_____	\$ _____
Notes	_____	_____	\$ _____
Unpaid Bills	_____	_____	\$ _____
Other	_____	_____	\$ _____
TOTAL LIABILITIES			\$ _____

So that we have accurate contact information and are able to inform children, grandchildren and friends of the many activities and religious life programs, please provide us with the following information.

FAMILY AND FRIENDS

Name _____ Relationship _____ Spouse _____

Address _____

Phone _____
Home Office Cell Email

Congregation _____

Medical information can be shared with this individual Yes No

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Name \_\_\_\_\_ Relationship \_\_\_\_\_ Spouse \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_  
Home Office Cell Email

Congregation \_\_\_\_\_

Medical information can be shared with this individual  Yes  No

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Name _____ Relationship _____ Spouse _____

Address _____

Phone _____
Home Office Cell Email

Congregation _____

Medical information can be shared with this individual Yes No

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Name \_\_\_\_\_ Relationship \_\_\_\_\_ Spouse \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_  
Home Office Cell Email

Congregation \_\_\_\_\_

Medical information can be shared with this individual  Yes  No

**GUARANTOR** The individual or organization that agrees to act on behalf of the Resident to fulfill all covenants, conditions and promises made and agreed to by the Resident under the Residency and Service Agreement and be personally liable to pay all costs incurred by the Resident.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_

**BILLING PARTY** The individual or organization responsible for making the cash disbursement in response to the bill from the facility (may or may not be the Guarantor).

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_

**REPRESENTATIVE** The individual responsible for making arrangements for the resident in the case of any emergency or in the event that she/he can no longer reside at the Mildred Shor Inn.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_

**CERTIFICATION**

I certify that each and every statement set forth above, including any accompanying financial records, is true and correct. I understand that the Abramson Center for Jewish Life's agreement to admit applicant to the Mildred Shor Inn is expressly made in reliance on the information contained herein. I understand that any material omissions or misrepresentations shall constitute a breach of the Residency and Service Agreement and may result in termination of residency.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



# PRE-ADMISSION MEDICAL EVALUATION

1425 Horsham Road • North Wales, PA 19454-1320  
Telephone 215-371-2100 Fax 215-371-3030

Dear Doctor \_\_\_\_\_:

Your patient, \_\_\_\_\_, is applying to the Mildred Shor Inn – Personal Care Apartments at the Abramson Center for Jewish Life. This form is required to complete their application.

### CURRENT MEDICAL PROBLEMS

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### ALLERGIES

### CURRENT MEDICATIONS

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Does this patient have the cognitive ability to communicate basic needs?  Yes  No

Is this patient safe to reside in a non-secured community setting?  Yes  No

Is this patient able to ambulate independently with or without an assistive device?  Yes  No

Is this patient on a special diet? No  If yes, what type? \_\_\_\_\_

Identify this patient's needs for supervision:

- No supervision needs
- Occasional checking needed
- Needs 24-hour supervision
- Needs supervision only at certain times of day or during certain activities  
(Specify activities/times) \_\_\_\_\_

### CURRENT TREATMENTS (OT/PT/Speech/Wound Dressings/Catheter Orders, etc.)

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician Name (Print) Date Signature

\_\_\_\_\_  
Office Address Phone

Thank you for your assistance.