



## APPLICATION FOR MOVE-IN

Madlyn and Leonard  
Abramson Center for Jewish Life  
1425 Horsham Road • North Wales, PA 19454-1320  
Telephone 215-371-3605 Fax 215-371-3030  
www.abramsoncenter.org

### **APPLICANT INFORMATION**

Name

*Last*

*First*

*Middle Initial*

Address

City

State

Zip

Telephone

Previous Address

City

State

Zip

From

To

Gender  male  female

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_

Birthplace

U.S. Citizen  Yes  No

Social Security #

Education

Former Occupation

Date Retired /

Marital Status  Single  Married  Widowed  Divorced I have a  Spouse  Significant Other

Spouse Name

Social Security #

Number of Children

Number of Grandchildren

Number of Great Grandchildren

Hebrew Name

Parent's Hebrew Names

#### **How did you hear about the Abramson Residence?**

Friend

Center Program

(name)

(name)

Board Member

Organization

(name)

(name)

Social Worker

Internet

(name)

Other

**Through joint programming, the 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 association.

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 to the Residence to notify the synagogue and/or organization of the applicant's new residency?  Yes  No

### **INSURANCE**

*In order to process the application, please include a copy of all insurance cards*

**Medicare #** \_\_\_\_\_

Effective Date - Part A \_\_\_\_\_

Part B \_\_\_\_\_

**Name of Supplemental Health Insurance Company** \_\_\_\_\_

ID # \_\_\_\_\_

Group \_\_\_\_\_

**HMO** \_\_\_\_\_

ID# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Has the applicant had any admissions to other nursing/rehabilitation centers within the last 12 months prior to this application?  NO  YES If yes, please list name(s) of facility(s) and dates of service  
\_\_\_\_\_

**Private Long Term Care Insurance -** *In order to process the application, please attach copy of policy*

Company Name \_\_\_\_\_

Policy # \_\_\_\_\_

Address \_\_\_\_\_

### **Life Insurance**

Company Name \_\_\_\_\_

Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_

Face Value \_\_\_\_\_

Cash Value \_\_\_\_\_

**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***

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

***In order to process this application, please attach a copy of the last five (5) years of account statements for the items listed below and the last five (5) years of 1040 tax returns. Current financial information must be provided on or about the time of move-in.***

**INCOME:**

		<u>Applicant</u>	<u>Spouse</u>
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	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>		\$ _____	\$ _____

**ASSETS:**

	Institution	Account #	<u>Applicant</u>	<u>Spouse</u>
Savings Account	_____	_____	\$ _____	\$ _____
Checking Account	_____	_____	\$ _____	\$ _____
Certificates	_____	_____	\$ _____	\$ _____
Stocks	_____	_____	\$ _____	\$ _____
Bonds	_____	_____	\$ _____	\$ _____
Mutual Funds	_____	_____	\$ _____	\$ _____
Trust Funds	_____	_____	\$ _____	\$ _____
Retirement Accts	_____	_____	\$ _____	\$ _____
Real Estate Attach Copy of Deed	_____	_____	\$ _____	\$ _____
Other Resources Please Specify	_____	_____	\$ _____	\$ _____
<b>TOTAL ASSETS</b>			\$ _____	\$ _____

**SHELTER COSTS:**  
*excluding utilities*

i.e. Rent, Mortgage, real estate taxes, home equity loans,  
homeowner insurance, etc.

\$ \_\_\_\_\_

**Please check Utility services:**

Heat & Air condition       Electricity       Telephone

**LIABILITIES:**

	Description	Payable to Bank, Person, etc.	Amount per Month
Mortgage	_____	_____	\$ _____
Loans	_____	_____	\$ _____
Notes	_____	_____	\$ _____
Unpaid Bills	_____	_____	\$ _____
Other	_____	_____	\$ _____
<b>TOTAL LIABILITIES</b>			\$ _____
<b>NET ASSETS</b>			\$ _____

Have contributions been made to any of the above assets by anyone other than the applicant?

NO  YES If yes, by whom and amount \_\_\_\_\_

**Transfer of Assets**

The Department of Public Welfare states that any applicant shall be ineligible, if within 60 months prior to the date of application for Medical Assistance, he/she had made a transfer or other disposition of assets for less than fair market value for the purpose of qualifying for Medical Assistance.

Within the past five years, has the applicant transferred money, insurance, real estate, or personal property?

NO  YES If greater than \$500, please specify:

Amount	To Whom	When

**Trust**

Does the applicant receive income from or have a trust?  NO  YES

Within the past five years, has the applicant transferred money into, or established a trust?  NO  YES

Amount \$ \_\_\_\_\_ **If yes, please attach a copy of the Trust Agreement.**

Trustee \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Funeral/Burial Arrangements**

Have funeral/burial arrangements been made?  NO  YES

If yes, are arrangements paid in full and irrevocable?  NO  YES

Funeral Home \_\_\_\_\_ Cemetery \_\_\_\_\_

Institution with burial reserve account \_\_\_\_\_

**Are you represented by an attorney?**

NO  YES If yes, please provide the following information.

Attorney \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**PAYMENT**

Monthly care charges are to be paid by *(please check all applicable boxes)*:

Applicant's own resources  Other (specify) \_\_\_\_\_

State Medical Assistance (Medicaid)

Has the application been initiated?  NO  YES

If yes, date initiated \_\_\_\_\_ caseworker \_\_\_\_\_



**FAMILY AND FRIENDS** *(continued)*

Name	Relationship	Spouse
Address		
Phone		
Home	Office	
Cell	Email	
Congregation		
Contact for Medical Decisions	YES NO <input type="checkbox"/> <input type="checkbox"/>	Contact for Financial Decisions YES NO <input type="checkbox"/> <input type="checkbox"/>



Name	Relationship	Spouse
Address		
Phone		
Home	Office	
Cell	Email	
Congregation		
Contact for Medical Decisions	YES NO <input type="checkbox"/> <input type="checkbox"/>	Contact for Financial Decisions YES NO <input type="checkbox"/> <input type="checkbox"/>

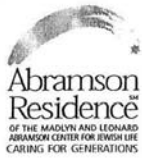
**CERTIFICATION**

I understand that no application is considered for move-in to the Abramson Residence until all requested information is furnished.

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 Abramson Residence is expressly made in reliance on the information contained herein. I understand that any material omissions or misrepresentations shall constitute a breach of the Admission Agreement and may result in termination of residency.

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

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_



## PRE-ADMISSION MEDICAL EVALUATION

Dear Dr. \_\_\_\_\_,

Your patient, \_\_\_\_\_, is applying for admission to the Abramson Residence for nursing care. A signed authorization for release is enclosed. Please fill out this form completely and include all requested information. Thank you, in advance, for helping us evaluate your patient for a possible move to our Center.

**CURRENT MEDICAL PROBLEMS:** (include behaviors):

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**CURRENT MEDICATIONS:** (Dose and frequency):

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**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BLOOD PRESSURE:** \_\_\_\_\_ / \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

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**VACCINATIONS / TB TESTS:** (Include dates as known)

Influenza: \_\_\_\_\_ Pneumococcal: \_\_\_\_\_ Tetanus: \_\_\_\_\_ PPD: \_\_\_\_\_

**DIET:** (Include type, consistency and supplements)

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**CURRENT TREATMENTS:** (OT, PT, Speech Tx, Wound Care, Catheters, Oxygen Supplements, Behavior Plans, etc.)

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**SPECIALTY NEEDS / APPLIANCES:**

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**CURRENT AMBULATION:**

Independent \_\_\_ Cane \_\_\_ Walker \_\_\_ Wheelchair \_\_\_ Braces \_\_\_

Restraints (Please explain) \_\_\_\_\_

**PLEASE ATTACH COPIES OF:**

\_\_\_\_\_ Complete H & P  
\_\_\_\_\_ Progress Notes  
\_\_\_\_\_ Mini-Mental Exam

\_\_\_\_\_ Recent Labs, EKG's, X-Rays  
\_\_\_\_\_ Care Plan for Behaviors

Thank you for your assistance.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name (Print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone