Mildred Shor Inn℠
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 _____ ☐Center Program _____
(name) *(name)*
☐Board Member _____ ☐Organization _____
(name) *(name)*
☐Social Worker _____ ☐Internet
(name)
☐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

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Name Relationship Spouse

Address

Phone

Home Office Cell Email

Congregation

Medical information can be shared with this individual ❒ Yes ❒ No

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Name Relationship Spouse

Address

Phone

Home Office Cell Email

Congregation

Medical information can be shared with this individual ❒ Yes ❒ No
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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 personably 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

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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

_____

_____

_____

ALLERGIES_____

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

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.)*

_____

_____

_____ ___/___/___ _____
Physician Name (Print) Date Signature

_____
Office Address Phone

Thank you for your assistance.

Rev. 12/10