



**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 \_\_\_\_\_

*Please include any paperwork relevant to the Medicaid application.*

So that we have accurate contact information, including email address 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 \_\_\_\_\_  
Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO



Name \_\_\_\_\_ Relationship \_\_\_\_\_ Spouse \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_  
Cell \_\_\_\_\_ Email \_\_\_\_\_  
Congregation \_\_\_\_\_  
Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO



Name \_\_\_\_\_ Relationship \_\_\_\_\_ Spouse \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_  
Cell \_\_\_\_\_ Email \_\_\_\_\_  
Congregation \_\_\_\_\_  
Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO

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

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

Address \_\_\_\_\_

Phone \_\_\_\_\_

Home

Office

Cell

Email

Congregation \_\_\_\_\_

Contact for Medical Decisions      YES NO      Contact for Financial Decisions      YES NO  
      

Why is the nursing home setting being considered at this time? \_\_\_\_\_

What is the prospective resident able to do for themselves at this time? \_\_\_\_\_

What type of care related activities does he/she need assistance with at this time? \_\_\_\_\_

Who presently is providing care for him/her at this time? \_\_\_\_\_

What are the special medical issues at this time? \_\_\_\_\_

What are the special behavioral issues at this time (wandering, repetitiveness, crying, spitting, hitting, etc)? \_\_\_\_\_

**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:**

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### **CURRENT PSYCHIATRIC PROBLEMS:**

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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	_____ Recent Labs, EKG's, X-Rays
_____ Progress Notes	_____ Care Plan for Behaviors
_____ Mini-Mental Exam	

Thank you for your assistance.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone





CARE ADVISORS   SHORT STAY REHAB   HOME CARE   RESIDENTIAL CARE  
 MEDICAL ADULT DAY SERVICES   DIALYSIS   HOSPICE   RESEARCH

Welcome to the Abramson Center. We are eager to learn about how to best care for your loved one. Your feedback will help us to facilitate a smooth transition to the nursing home setting. We appreciate your timely response to completing this inventory. The care team will incorporate this information into a personalized plan of care.

Section 1. The Emotional Well-Being Inventory asks a series of questions related to your loved one’s specific care needs. These questions will help prepare us to respond to your loved one in a way that brings comfort and is most helpful to them. Feel free to use back side of page if more space is needed to answer the questions.

Section 2. Preferences for Everyday Living Inventory © asks detailed questions to get to know what is important to your loved one about their daily routine.

**Section 1. Emotional Well Being**

**A. Please describe what brings joy or pleasure to your loved one in a typical day?**

**B. What are some ways that we can assist your loved one to feel comfortable in their new home?**

**C. In what ways would your loved one like staff to show them respect? (for example, greeting you, using your preferred name, knocking before entering room, thanking you, listening to you, honoring your feelings, etc.)**

**D. Please indicate the kind of emotional challenges you may have experienced with your loved one? Check all that apply.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aggression towards Others | <input type="checkbox"/> Fear/Anxiety         | <input type="checkbox"/> Refusal of              |
| o Verbal   | <input type="checkbox"/> Impulsivity          | o Care   |
| o Physical   | <input type="checkbox"/> Insomnia             | o Activities                                     |
| <input type="checkbox"/> Aggression towards Self   | <input type="checkbox"/> Isolation/Withdrawal | o Medication                                     |
| o Verbal   | <input type="checkbox"/> Sun downing          | o Food   |
| o Physical   | <input type="checkbox"/> Wandering            | <input type="checkbox"/> Other: Please Describe: |
| <input type="checkbox"/> Crying/Tearfulness        | <input type="checkbox"/> Yelling/Calling out  | <input type="checkbox"/> Not applicable:         |

**For any of the emotional challenges noted above, please.....**

**1. Describe specific events or interactions that may precipitate your loved one experiencing distress?**

**2. Indicate if there are any environmental factors that may cause upset? Check all that apply**

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Clutter                       | <input type="checkbox"/> Lighting | <input type="checkbox"/> Room Temperature |
| <input type="checkbox"/> Crowds/Large Groups of People | o Too Bright                      | o Too Hot                                 |
| <input type="checkbox"/> Noise                         | o Too Dim                         | o Too Cold                                |
| <input type="checkbox"/> Other Please describe: _____  |                                   | <input type="checkbox"/> Not applicable   |

**3. Is there a typical time of day that your loved one experiences distress? \_\_\_ NO (skip to #4) \_\_\_ YES What time of day?**

- |                                  |                                    |                                  |
|----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
|----------------------------------|------------------------------------|----------------------------------|

**E. Describe what you have done to help your loved one feel better when they are experiencing an emotional challenge?**

**F. Is there anything else we should know in order to best support your loved one’s emotional well-being?**

**Section 2. Preferences for Everyday Living Inventory**

- The next series of questions should be completed by asking your loved one about their preferences for everyday living. If they are not able to respond, please complete the survey to the best of your ability using your knowledge of their preferences (past or current).
- Each preference question asks you to select how important that preference is to your loved one. Indicate either “Important” or “Not important”.
- If the preference is important, please include additional details using the follow-up questions. If the preference is not important, you can proceed to next question. Add any additional details in the “Notes”.
- The care team will use this preference information to develop a plan of care that meets his/her preferences to the best of their ability.

**1. How important is it to you (your loved one) to choose when to get up in the morning?**

Select importance level below      If important, check all that apply

IMPORTANT       Earlier than 6 am     Between 6-8 am     After 8am     Whenever I wake up

NOT IMPORTANT

Notes:

**2. How important is it for you (your loved one) to follow a routine when you wake up in the morning?**

Select importance level below      If important, check all that apply

IMPORTANT      What is part of your morning routine?

NOT IMPORTANT

Relax in bed       Watch TV       Brush teeth       Cigarette

Drink coffee/tea     Listen to radio     Bathe/wash-up     Other: \_\_\_\_\_


Read newspaper     Get dressed       Take medication


Comments on order of morning routine:

Notes:

**3. How important is it to you (your loved one) to choose what time of day to bathe?**

Select importance level below

IMPORTANT 

NOT IMPORTANT 

If important, check all that apply

What time of day do you like to bathe?

Morning     Afternoon     Evening


Do you prefer a shower or bath?


Shower     Bath     Other:

Notes:

**4. How important is it to you (your loved one) take a nap when you wish?**

Select importance level below

IMPORTANT 

NOT IMPORTANT 

If important, check all that apply


When do you usually like to take a nap?


Morning     Evening/night     Afternoon     When I want

Notes:

**5. How important is it to keep your (loved one's) room at a certain temperature?**

Select importance level below

IMPORTANT 

NOT IMPORTANT 

If important, check all that apply


At what temperature do you like to keep your room?


Average (69-72 degrees)     On the warm side (>72 degrees)  
 On the cool side (<69 degrees)

Notes:

**6. How important is it to you to choose your (your loved one's) own bedtime?**

Select importance level below

IMPORTANT 

NOT IMPORTANT 

If important, check all that apply

What time do you like to go to bed?

Earlier than 7 pm     7-9 pm     After 9pm

Notes:

**7. How important is it to follow a routine when you (your loved one) go to bed?**

Select importance level below

**IMPORTANT** →

**NOT IMPORTANT**

If important, check all that apply

Tell me about your bedtime routine:

Notes:

**8. How important is it to you to choose whether your (loved one's) daily caregiver is male or female?**

Select importance level below

**IMPORTANT** →

**NOT IMPORTANT**

If important, check all that apply

Which gender caregiver do you like for personal care (e.g., showering, dressing, toileting)?:

Female     Male

Notes:

**9. How important is it to you (your loved one) to choose what to eat?**

Select importance level below

**IMPORTANT** →

**NOT IMPORTANT**

If important, check all that apply

What are your favorite foods for:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_

Supper: \_\_\_\_\_ Favorite Snacks: \_\_\_\_\_

Favorite Drinks: \_\_\_\_\_ Condiments: \_\_\_\_\_

Foods I dislike: \_\_\_\_\_ Foods Allergies: \_\_\_\_\_

Do you have any dietary restrictions?:

Vegetarian     Vegan     Gluten-free     Other: \_\_\_\_\_

What is your typical daily eating pattern?:

Notes:

**10. How important is it to you (your loved one) to do your favorite activities?**

Select importance level below

**IMPORTANT** →

**NOT IMPORTANT**

If important, check all that apply

What are you favorite activities? (Examples: reading, sitting outside, watching movies, being with your family?)

Notes:



Thank you so much for your feedback. Feel free to let us know if you have any additional questions.

Date Completed \_\_\_\_\_