KINKORA PYTHIAN HOME CORPORATION
25 COVE ROAD
DUNCANNON, PA 17020
(717) 834-4887

ADMISSION APPLICATION FOR:

NURSING CARE: _____ PERSONAL CARE: _____

_____ Private Room _____ Private Room
_____ Semi-Private Room _____ Semi-Private Room

DESIRED ADMISSION DATE: _____

APPLICANT INFORMATION

APPLICANT'S NAME: _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH _____

SEX: _____ AGE: _____ MARITAL STATUS: _____

NAME OF SPOUSE (If Applicable) _____

ADDRESS: _____

_____ TELEPHONE NUMBER: _____

PLEASE LIST BELOW, EACH LIVING CHILD, BEGINNING WITH THE ELDEST:
(If none, please list nearest relatives and friends)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE #: _____

_____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE #: _____

_____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE #: _____

_____

PLEASE INDICATE IF APPLICABLE:

Durable Power of Attorney _____ Name _____

Financial Power of Attorney _____ Address _____

Financial Trust Officer _____ _____

Guardian _____ Telephone # _____

NAME AND TELEPHONE NUMBERS OF THREE PERSONS TO BE CONTACTED IN THE EVENT OF AN EMERGENCY:

NAME	HOME PHONE	WORK PHONE

Physician's Name _____ Telephone # _____

Address _____

Is applicant currently in the hospital? YES _____ NO _____

If yes, Name and Address of hospital _____

_____

Floor/Unit # _____ Telephone # _____

Hospital Preference (if needed to be admitted): _____
Church Name _____ Telephone # _____

Pastor's Name _____ Telephone # _____

Have Funeral Arrangements been made? YES _____ NO _____

Funeral Home's Name _____ Telephone # _____

Address _____

_____

FINANCIAL INFORMATION

Name of the "Resident":_____

Name of the Responsible Person (optional):_____

Telephone No.: _____Work No.:_____ Other No.: _____

Has a trust fund been established for the Resident? ____Yes ____ No

Has a Power of Attorney been conferred on the person(s) to be financially responsible, or on the person(s) who will act on behalf of the resident. ("Responsible Party")? _____ Yes _____ No If yes, please provide a copy.

Has a legal guardian been appointed by a court? _____ Yes _____ No
If yes, please provide a copy.

Has a burial trust been established? _____ Yes _____ No
If yes, with whom? _____
If no, who is the preferred funeral service for the Resident family?
_____

ASSETS:	**RESIDENT**
Cash	$_____
Checking	$_____
Savings	$_____
Money-Market	$_____
Certificates of Deposit	$_____
Securities (Stocks/Bonds)	$_____
Trust	$_____
Annuities (if not yet paying monthly)	$_____
IRA	$_____

MONTHLY INCOME	**RESIDENT**
Salary	$_____
Social Security	$_____
Pensions/Annuities (if not above)	$_____
IRA (if not above)	$_____
Interest/Dividend Income	$_____
Rental Income	$_____
Trust	$_____
Investments/Other	$_____
Long-Term Care Insurance	$_____

REAL ESTATE (description/location)

Property: _____ _____
Name on Deed/Title _____

Property: _____ _____

Name on Deed/Title _____

OTHER ASSETS

Cash Value Life Insurance	_____
Vested Pension Benefits	_____
Business Interests	_____
Automobiles	_____
Other	_____
TOTAL ASSETS:	_____

LIABILITIES	**RESIDENT**
Home Mortgage	$_____
Credit Cards/Charge Accounts	$_____
Loans	$_____
Other Debts	$_____
Taxes Owed	$_____
Total Liabilities:	$_____

NET WORTH: $_____
(assets – liabilities)

PLEASE SIGN BELOW:

I hereby warrant and represent that the information provided is accurate and complete. I understand that Kinkora Pythian Home will rely upon the accuracy and completeness of the above financial information in making an admission decision. I also understand that if any of the information is not accurate or not complete, the Facility will have detrimentally relied upon the above financial information and will suffer financial loss and harm. The assets listed are in fact available to the resident to pay for the Resident's care.

_____ _____

Resident's or Responsible Party's Signature Date

_____ _____

Guarantor's Signature Date

Reviewed by:

_____ _____

Admission's director Signature Date

_____ _____

Administrator's Signature Date

INSURANCE INFORMATION

Are you enrolled in Medicare? YES _____ NO _____

Medicare # _____ Part "B" YES _____ NO _____

Do you have Blue Cross/Blue Shield 65? YES _____ NO _____ Plan # _____

If Individual Coverage: Plan A B C H (please circle one)

Do you belong to an "HEALTH MAINTENANCE ORGANIZATION", "PREFERRED PROVIDER ORGANIZATION"? YES _____ NO _____

If YES - Name of Company: _____ Plan #_____

Do you have any other Health Insurance Coverage: YES _____ NO _____

If YES – Name of Company: _____ Plan # _____

Do you have Long Term Care Insurance Coverage? YES _____ NO _____

Are you eligible for or receiving "Medical Assistance"? YES _____ NO _____

If YES – Recipient # _____

Have you sold, transferred, or given away a home, land or personal property (including cash) in the past 36 months? YES _____ NO _____

MEDICAL INFORMATION

Reason(s) for desiring admission: _____

_____

Please indicate in full detail any illness, physical limitations or recent operations:

_____

_____

_____

Current Medications: _____

_____

Please list any Allergies: _____

Please list any Medical Equipment the applicant may be currently using: _____

Does the Applicant have a History of Mental Illness: YES _____ NO _____

If YES, please explain: _____

Is the Applicant receiving any Home Health or Rehabilitative Services? YES _____ NO _____

If YES, please explain: _____

Does the Applicant Smoke? YES _____ NO _____ How Often _____

Does the Applicant use Alcohol? YES _____ NO _____ How Much _____

Has the Applicant ever required treatment relating to Alcohol or Drug Addiction? YES _____ NO _____

If YES, please explain: _____

Please list any special diet requirements, food likes, dislikes and or allergies: _____

PLEASE CHECK AT LEAST ONE OF ALL THE FOLLOWING CATEGORIES:

AMBULATION: Fully Ambulatory _____ With 1 person assisting _____ With 2 persons assisting _____
Wheelchair _____ Walker/Cane _____ Bed _____

HEARING: Good _____ Impaired _____ Deaf _____ Hearing Aid _____

VISION: Good _____ Impaired _____ Blind _____ Glasses _____

DENTAL: Has own Teeth _____ Has Dentures _____ Upper _____ Lower _____

PROSTHESIS: Please Specify _____

OXYGEN: Required Always _____ Required at Times _____ Not Required _____

SPEECH: Can be Understood _____ Hard to Understand _____

DECUBITUS: Drainage _____ Dressings _____ WHERE?_____

BOWELS: Continent _____ Occasional Incontinence _____ Incontinent _____
Ostomy (please specify) _____

BLADDER: Continent _____ Occasional Incontinence _____ Incontinent _____ Catheter _____

BATHING: Independent _____ With Assistance _____ Tub _____ Shower _____

DRESSING: Independent _____ With Assistance _____ Total Care _____

GROOMING: Independent _____ With Assistance _____ Total Care _____

FEEDING: Independent _____ With Assistance _____ Nasal/Gastro Tube _____

DIABETIC: Yes _____ No _____ Please Explain _____

THERAPIES: Physical _____ Occupational _____ Speech _____
(Please indicate if applicant has or is currently receiving any of the above therapies)

MENTAL STATUS: Oriented _____ Confused at Times _____ Always Confused _____

ALERT: Aware of Surroundings _____ Wanders _____ Noisy _____ Combative _____

SLEEP HABITS: Full Night _____ Intervals _____ Walks in Sleep _____

DECISION MAKING: Independent _____ Needs Assistance _____ Unable _____

CONVERSATIONAL: Talkative _____ Normal _____ Quiet _____

EMOTIONAL: Positive Attitude _____ Negative Attitude _____ Withdrawn _____
Confident _____ Fearful _____ Irritable _____ Depressed _____ Happy _____
Pleasant _____ Realistic _____ Imagines Things _____ Easy Going _____
Defensive _____ Good Memory _____ Forgets _____

I understand that Kinkora Pythian Home Corporation retains the right to accept or reject any application consistent with the law. I certify that all of the information submitted on this application is true and correct, and I understand the submission of False information may constitute grounds for rejection of this application or my discharge after admission.

_____ _____
Signature of Applicant or Responsible Party Date