



Abramson Senior Care
1425 Horsham Road • North Wales, PA 19454-1320
Telephone: 215.371.3400 • Fax: 215.371.3030
abramsonseniorcare.org

APPLICANT INFORMATION

Name

Last

First

Middle Initial

Please call me: _____

Address

City

State

Zip

Telephone

Gender _____ Date of Birth ____/____/____ Age _____

U.S. Citizen Yes No

Social Security #

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

Spouse Name _____ Funeral Home _____

Birth Place: _____ Education: _____ Former Occupation: _____

OPTIONAL: Religious Congregation: _____

Would you like us to contact on your behalf? 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

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***

EMERGENCY CONTACTS

Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Contact for Medical Decisions YES NO

Contact for Financial Decisions YES NO

Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Contact for Medical Decisions YES NO

Contact for Financial Decisions YES NO

Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Contact for Medical Decisions YES NO

Contact for Financial Decisions YES NO

CERTIFICATION

I certify that each and every statement set forth above is true and correct. I understand that the Abramson Center for Jewish Life's agreement to admit applicant to Birnhak Transitional Care 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 a discharge.

Applicant Signature

Date

Responsible Party Signature

Date