Abramson Senior Care

APPLICATION FOR MOVE-IN

1425 Horsham Road • North Wales, PA 19454-1320
Telephone: 215.371.3605 Fax: 215.371.3030
abramsonseniorcare.org

APPLICANT INFORMATION

Name

Last *First* *Middle Initial*

Please call me: _____

Address

City State Zip Telephone

Previous Address

City State Zip From To

Gender: _____ 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 *(name)* ☐Center Program *(name)*

☐Board Member *(name)* ☐Organization *(name)*

☐Social Worker *(name)* ☐Internet

☐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:

		Applicant	Spouse
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 #	Applicant	Spouse
Savings Account	_____	_____	$_____	$_____
Checking Account	_____	_____	$_____	$_____
Certificates	_____	_____	$_____	$_____
Stocks	_____	_____	$_____	$_____
Bonds	_____	_____	$_____	$_____
Mutual Funds	_____	_____	$_____	$_____
Trust Funds	_____	_____	$_____	$_____
Retirement Accts	_____	_____	$_____	$_____
Real Estate **Attach Copy of Deed**	_____	_____	$_____	$_____
Other Resources **Please Specify**	_____	_____	$_____	$_____
TOTAL ASSETS			$_____	$_____

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 _____ _____ $_____

TOTAL LIABILITIES $_____

NET ASSETS $_____

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

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

Name Relationship Spouse

Address

Phone

Home Office

Cell Email

Congregation

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

Name Relationship Spouse

Address

Phone

Home Office

Cell Email

Congregation

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

FAMILY AND FRIENDS *(continued)*

Name Relationship Spouse

Address

Phone

Home Office

Cell Email

Congregation

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

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 Senior Care 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

Abramson Residence℠
OF THE MADLYN AND LEONARD ABRAMSON CENTER FOR JEWISH LIFE
CARING FOR GENERATIONS

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:

_____

_____

_____

_____

CURRENT PSYCHIATRIC PROBLEMS:

_____

_____

_____

_____

CURRENT MEDICATIONS: (Dose and frequency):

_____

_____

_____

_____

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____ / _____

ALLERGIES: _____

_____

VACCINATIONS / TB TESTS: (Include dates as known)

Influenza: _____ Pneumococcal: _____ Tetanus: _____ PPD: _____

DIET: (Include type, consistency and supplements)

_____

_____

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

_____

_____

_____

_____

SPECIALTY NEEDS / APPLIANCES:

_____

_____

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

Abramson Senior Care

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.

- ☐ Aggression towards Others
  - o Verbal
  - o Physical
- ☐ Aggression towards Self
  - o Verbal
  - o Physical
- ☐ Crying/Tearfulness
- ☐ Fear/Anxiety
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Isolation/Withdrawal
- ☐ Sun downing
- ☐ Wandering
- ☐ Yelling/Calling out
- ☐ Refusal of
  - o Care
  - o Activities
  - o Medication
  - o Food
- ☐ Other: Please Describe:
- ☐ 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

- ☐ Clutter
- ☐ Crowds/Large Groups of People
- ☐ Noise
- ☐ Other Please describe: _____
- ☐ Lighting
  - o Too Bright
  - o Too Dim
- ☐ Room Temperature
  - o Too Hot
  - o Too Cold
- ☐ 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?

☐ Morning	☐ Afternoon	☐ 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**

What time do you usually like to get up in the morning?

☐ 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**

□ **NOT IMPORTANT**

What is part of your morning routine?

□ 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 **If important, check all that apply**

□ **IMPORTANT**

□ **NOT IMPORTANT**

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 **If important, check all that apply**

□ **IMPORTANT**

□ **NOT IMPORTANT**

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 **If important, check all that apply**

□ **IMPORTANT**

□ **NOT IMPORTANT**

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 **If important, check all that apply**

□ **IMPORTANT**

What time do you like to go to bed?

□ Earlier than 7 pm □ 7-9 pm □ After 9pm

□ **NOT IMPORTANT**

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:

Stop

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

Date Completed_____