Application for Move-In
Abramson Senior Care

1425 Horsham Road • North Wales, PA 19454-1320
Telephone: 215.371.2102 Fax: 215.371.3030
abramsonseniorcare.org

RESIDENT INFORMATION

Name *LAST* *First* *Middle Initial*

Please call me: ____

Address

City State Zip Telephone: (home) (cell)

Previous Address

City State Zip From To

Gender: ______________________ Date of Birth _____/_____/______ Age: _________

Birthplace Social Security #

Education Former Occupation

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

Number of Children Number of Grandchildren Number of Great Grandchildren

Hebrew Name Parent's Hebrew Names

How did you hear about The Inn for Assisted Living?

☐ Friend *(name)*	☐ Center Program *(name)*
☐ Board Member *(name)*	☐ Organization *(name)*
☐ Social Worker *(name)*	☐ 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 to The Inn 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*

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 #	Amount
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

Relationship Spouse

Name

Address

Phone

Home Office Cell Email

Congregation

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

Relationship Spouse

Name

Address

Phone

Home Office Cell Email

Congregation

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

Relationship Spouse

Name

Address

Phone

Home Office Cell Email

Congregation

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

GUARANTOR The individual or organization who 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 personally liable to pay all costs incurred by the Resident.

Name Relationship

Address

Telephone (home) (office) (cell)

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) (cell)

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 Inn.

Name Relationship

Address

Telephone (home) (office) (cell)

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 Senior Care's agreement to admit applicant to the 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

ADM 2/19

Mildred Shor Inn™
OF THE MADLYN AND LEONARD ABRAMSON CENTER FOR JEWISH LIFE
CARING FOR GENERATIONS

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