Home with the Heart
Continuing Care Community
A ministry of the Sisters of Saints Cyril and Methodius

Continuing Care Community
Health/Social Application

The information that is requested on this form is essential for processing the applicant's admission. Avoid delays by completing all sections in a thorough and accurate manner.

Applicant's Information

Last Name//First Name//Middle Name			
Maiden Name (If Applicable)			
Name of Preference (Nickname)			
Gender			
Permanent Mailing Address			
Permanent Phone Number	**( ) -**		
County Which Applicant Lives			
Date of Birth		**Age**	
Social Security #	**- -**		
Where is the applicant currently?	☐ **Private Residence** ☐**Personal Care Home** ☐**Nursing Home** ☐**Hospital** **Provide Facility Name:**		
Does the applicant live with family/others	☐ **No** ☐ **If Yes, with whom:**		

Applicant Preferences

Has the applicant been admitted to Maria Joseph CCC previously?	☐ **No** ☐**If Yes, When (estimate if necessary):**
Room Preference	☐ **Private** ☐**Semi-Private** ☐ **No Preference/First Available** ☐**Isolation**
Anticipated Level of Care	☐ **Independent Living** ☐ **Personal Care** ☐ **Secure Personal Care** ☐ **Rehabilitation/Short-Term Stay** ☐ **Nursing (Long-term)**

Healthcare Information

Geisinger Medical Record Number (If Applicable)			
Family Physician's Name		Phone Number	**( ) -**
Dentist's Name		Phone Number	**( ) -**
Podiatrist's Name		Phone Number	**( ) -**

Primary Emergency Contact Information

Name // Relationship		
Mailing Address		
City / State / Zip		
Home Phone / Best Time	( ) -	
Work Phone / Best Time	( ) -	
Cell Phone/ Best Time	( ) -	

Secondary *Emergency Contacts*

(2) Name // Relationship		
Mailing Address		
City / State / Zip		
Home Phone / Best Time	( ) -	
Work Phone / Best Time	( ) -	
Cell Phone/ Best Time	( ) -	
(3) Name // Relationship		
Mailing Address		
City / State / Zip		
Home Phone / Best Time	( ) -	
Work Phone / Best Time	( ) -	
Cell Phone/ Best Time	( ) -	

Religion

Faith Tradition (If Applicable)	
Name of Religious Leader	
To which Parish/ Congregation/ does the applicant belong//Address? (If applicable)	
Does applicant give permission to disclose information to Religious Leader?	☐ **No** ☐ **Yes**

Social History

Full Maiden Name Of Applicant's Mother	
Name of Applicant's Father	

Marital Status (check one)	☐ **Never Been Married** ☐ **Widowed** ☐ **Married** ☐ **Divorced** ☐ **Separated**
Name of Spouse	
Spouse's Maiden Name	
Date of Marriage	
Location of Ceremony (City, State, Name of Church, etc.)	
If spouse is living, where does he/she currently reside?	
If spouse is deceased, what was the cause?	
Date of death?	
Number of Living Children?	
Number of Deceased Children?	
Number of Living Siblings?	
Number of Deceased Siblings?	

Employment History

What was the applicant's primary occupation?	
What year did the applicant retire?	
Reason for retirement?	

Educational Background

Grade School / Location		Years Completed
High School / Location		Years Completed
College / Vocational – Field of Study		Degree Acquired
Graduate – Field of Study		Degree Acquired

Military Background

Did the applicant serve in the U.S. Armed Forces?	☐ **Yes** ☐ **No**
Branch of service?	
Dates of service?	
War / Conflict?	
Did the applicant's spouse serve in the U.S. Armed Forces?	☐ **Yes** ☐ **No**

Demographic

Place of Birth?	
Is the applicant a U.S. Citizen?	☐ **Yes** ☐ **No**
How long has the applicant lived in the U.S.?	
How long has the applicant resided in PA?	
What is the applicant's ethnic background?	
Primary Language?	

Advance Directives

(1) Advance Directive Documents?	☐ **Yes** ☐ **No**	**Effective Date:**	**/ /**
(2) Power of Attorney for Healthcare?	☐ **Yes** ☐ **No**	**Effective Date:**	**/ /**
Name // Relationship			
(3) Durable Power of Attorney?	☐ **Yes** ☐ **No**	**Effective Date:**	**/ /**
Name // Relationship			

Care Needs Assessment

Activities of Daily Living	**Does the applicant feed him/herself? YES NO**	**Require total assistance feeding him/herself? YES NO** **Have any type of feeding tube? YES NO**
Hygiene	**Is the applicant able to brush his/her own hair? YES NO** **Brush his/her teeth/dentures? YES NO**	**Take a bath/shower independently? YES NO** **Dress him/herself independently? YES NO**
Mobility	**Does the applicant walk independently? YES NO** **Walk with a cane? YES NO** **Walk with a walker? YES NO** **Walk with crutches? YES NO** **Use a wheel chair? YES NO**	**Have a history of falling? YES NO** **Get in and out of bed independently? YES NO** **Stand up independently from a chair? YES NO** **Sits independently in a chair/recliner? YES NO**

Special Care	**Does the applicant have control of his/her bladder? YES NO** **Have control of his/her bowels? YES NO** **Have any open wounds/bedsores? YES NO**	**Have a colostomy? YES NO** **Have a urostomy? YES NO** **Have a catheter? YES NO** **Have to use oxygen? YES NO** **Nighttime Use Daytime Use** **Constant Use Liter Used: _____**
Impairments	**Does the applicant have difficulty seeing? YES NO** **Have difficulty hearing? YES NO** **Have difficulty speaking? YES NO** **Wear glasses? YES NO**	**Wear a hearing aid? YES NO** **Wear dentures? YES NO** **Have difficulty chewing? YES NO** **Have difficulty swallowing? YES NO**
Mental Status	**Is the applicant alert? YES NO** **Oriented? YES NO** **Occasionally confused? YES NO** **Confused all of the time? YES NO**	**Lethargic? YES NO** **Comatose? YES NO** **Cooperative? YES NO** **Combative? YES NO**
Psychiatric	**Has the applicant ever had any psychiatric treatment? YES NO**	**Is the applicant currently on any psychiatric medication? YES NO**

List all medications the applicant presently takes. (Include prescriptions, over-the-counter, antibiotics, and routine injections.)

_____
_____
_____
_____

Current Diagnosis:

_____
_____
_____
_____

Hospital Admissions (In the Past Year)	Facility _____ _____ _____	Approximate Date _____ _____ _____	Length of Stay _____ _____ _____	Reason _____ _____ _____
Nursing Home Admissions	Facility _____ _____ _____	Approximate Date _____ _____ _____	Length of Stay _____ _____ _____	Reason _____ _____ _____

List Prior Surgeries / Dates Is this list an estimate or accurate? (circle one)

_____
_____
_____

Health Insurance/Long Term Care

☐ Medicare A/B	Policy Number:
☐ Medicare Supplement Plan i.e. BC, BS, AARP – Specify:	Policy Number:
☐ Medicare Advantage Plan i.e. GHP Gold, Freedom Blue – Specify:	Policy Number:
☐ Medical Assistance	Policy Number:
☐ Other – Specify:	Policy Number
☐ Medicare D Plan – Specify:	Policy Number:
☐ PACE or PACE NET:	Policy Number:
☐ Nursing/Long Term Care	Policy Number:

Life Insurance & Burial Arrangements

Does the applicant have life Insurance?	☐ **Yes** ☐ **No**
Company of Life Insurance	
Policy Number of Life Insurance	

Burial Arrangements

Have burial arrangements been made for the applicant?	☐ **Yes** ☐ **No**	
Does the applicant have an Irrevocable Burial Account?	☐ **Yes** ☐ **No**	
Funeral Director – Name / Phone		**( ) -**
Full Address		
Place of Worship – Name // Phone		**( ) -**
Full Address		
Cemetery – Name // Phone		**( ) -**
Full Address		
Lot # // Lot Owner	#	

The undersigned acknowledge(s) that Maria Joseph CCC is relying on their representations and promises set forth herein considering the applicant for admission. We understand that if any information has been falsely represented, then that is sufficient cause for Maria Joseph CCC denial of this Application for Admission.

The financial information set forth herein is a true and correct statement of the applicant's current financial position. The undersigned acknowledge(s) that Maria Joseph CCC considers this application as a continuing statement of the applicant's financial condition and the undersigned agree(s) to furnish Maria Joseph CCC with an updated financial statement as follows:

a) At any time there is a change in the applicant's financial condition; or
b) Yearly when requested by Maria Joseph CCC; or
c) At any time the applicant is in need of a different level of care and/or desires to transfer to another facility owned or operated by Maria Joseph CCC or an affiliate of the Maria Joseph CCC and the applicant is applying to such different level of care or facility; or
d) At any time reasonably requested by Maria Joseph CCC in writing.

I, _____, do hereby give permission to Maria Joseph Continuing Care Community, to collect, to utilize, and to disclose the Health and Medical information collected on this form for the purpose of evaluating this application for admission.

_____ Date _____
Applicant's Signature

_____ Date_____
Legal Representative / Relationship to Applicant

_____ Date _____
Facility Representative / Title

Please bring the following cards: Social Security; Medicare; Medicaid; Pace; and Insurance. WE WILL MAKE COPIES AND RETURN THE CARDS TO YOU. Upon admission, our facilities will also need to make copies of any of the following the applicant may have: Living Will; Advance Directives; Power of Attorney; and/or Durable Power of Attorney for Health Care. Thank you.

Preserving the Tradition - Fulfilling the Mission

MariaJoseph Since 1962

Home with the Heart

Continuing Care Community

A ministry of the Sisters of Saints Cyril and Methodius

Continuing Care Community
Financial Application

The information that is requested on this form is essential for processing the applicant's admission. Avoid delays by completing all sections in a thorough and accurate manner.

Applicant's Name:

Guarantor Contact Information

Name // Relationship		
Mailing Address		
City / State / Zip		
Home Phone / Best Time	( ) -	
Work Phone / Best Time	( ) -	
Cell Phone/ Best Time	( ) -	

Financial Directives

Power of Attorney for Finances Designated	☐ **Yes** ☐ **No**	
Effective Date		
Name // Relationship		
Mailing Address		
Home Phone / Best Time	( ) -	
Work Phone / Best Time	( ) -	
Cell Phone/ Best Time	( ) -	
E-mail Address		

Financial Profile

Social Security	**$ /monthly**	**Veteran's Benefits**	**$ /monthly**
Miner's Benefits	**$ /monthly**	***Railroad* Benefits**	**$ *monthly***
Blind Assistance	**$ /monthly**	**SSI**	**$ /monthly**
Medicaid Benefits	**$ /monthly**	**Other – Specify**	**$ /monthly**

Pension – Specify **$** **/monthly**

Annuities – Specify **$** **/monthly**

Dividends – Specify **$** **/monthly**

Current Assets	**Saving/ Checking**	**$**
	Investments	**$**
	Real Estate	**$**

Health Insurance/Long Term Care

☐ Medicare A/B	Policy Number:
☐ Medicare Supplement Plan i.e. BC, BS, AARP – Specify:	Policy Number:
☐ Medicare Advantage Plan i.e. GHP Gold, Freedom Blue – Specify:	Policy Number:
☐ Medical Assistance	Policy Number:
☐ Other – Specify:	Policy Number
☐ Medicare D Plan – Specify:	Policy Number:
☐ PACE/PACE NET:	Policy Number:
☐ Nursing/Long Term Care	Policy Number:

Liabilities	***Amount***
Mortgage	**$**
Medical Insurance Premiums (i.e. Medicare A & B, Medicare Advantage Plans)	**$**
Life Insurance Premiums	**$**
Home Equity Loan	**$**
Auto Loan	**$**
Credit Cards	**$**
Nursing/Long Term Care Insurance	**$**

Other (please list):	**$**
Other (cont.):	**$**

Life Insurance & Burial Arrangements

Does the applicant have life Insurance?	**☐ Yes ☐ No**
Company of Life Insurance	
Policy Number of Life Insurance	
Does the applicant have Burial Arrangements	**☐ Yes ☐ No**
Prearranged with	
Irrevocable Burial Account	**☐ Yes ☐ No**
Amount of the Account	**$**
Account Held With	

Will

Holder of Will Name // Phone	
Full Address	
Executor – Name // Phone	
Full Address	
Attorney – Name // Phone	
Full Address	

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_____ Date _____
Applicant's Signature

_____ Date_____
Guarantor / Relationship to Applicant

_____ Date _____
Facility Representative / Title

The applicant has provided the following documentation:

_____ Income Tax Returns for the previous two years

_____ Savings and Checking Statements for last two months

_____ Verification of Real estate Value

Reviewed and Approved

Building Administrator: _____ Date _____

Billing Manager: _____ Date _____

COO (When Applicable) _____ Date _____

Application Committee _____ Date _____
(Independent Living)

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Continuing Care Community
Advanced Health Care Planning

Resident's Name:

Healthcare Directives: ***Upon the first few days of admission to the facility the Resident and/or his/her responsible health care agent will be provided with the opportunity to discuss advance healthcare planning (Advance Directive) with a member of the facility's staff and medical providers. Periodically and with a change in the resident's condition the medical provider and a member of the facility staff will review the resident's advanced health care directives with the resident/healthcare agent and update the resident's care plan.***

Resident/Healthcare Agent has been provided with information regarding Advance Directives?	☐ **Yes** ☐ **No**
Living Will Documented?	☐ **Yes** ☐ **No**
Effective Date of Living Will	
Healthcare Agent Designated?	☐ **Yes** ☐ **No** **Date:**
Name of Healthcare Agent	
Relationship to Applicant	
Effective Date of Healthcare Agent	
If Applicable – POLST form completed: (PA Orders for Life-Sustaining Treatment)	☐ **Yes** ☐ **No**
Effective Date of POLST	
Physician who has signed the POLST form?	
Out of Hospital DNR form completed: **(Independent Living & Personal Care Applicant Only)**	☐ **Yes** ☐ **No**
Effective Date of Out of Hospital DNR	
Physician who has signed the Out of Hospital DNR From?	**Name:** **Address:** **Phone:**
Resident/Responsible Party agreeable to discuss advanced health care planning	☐ **Yes** ☐ **No**
Interview with MJCCC Ethics Director/designee to be completed	**Date Scheduled:** **Date Completed:**
Signature Applicant or Legal Representative	
Signature of Ethics Director/Designee	