

Personal Care

APPLICATION FOR ADMISSION

The Shook Home
55 South Second Street
Chambersburg, PA 17201

1. Name _____ Telephone _____
Street _____
City _____ State _____ Zip Code _____
Date of Birth _____ Place of Birth _____
Married _____ Single _____ Widowed _____
2. Social Security Number _____ Citizenship _____
3. Name of husband or wife _____
Address (if living) _____
If deceased, place of burial _____ Date of Death _____
4. Closest living relatives including children:
Name _____ Relationship _____
Address _____ Telephone _____
Name _____ Relationship _____
Address _____ Telephone _____
Name _____ Relationship _____
Address _____ Telephone _____
Name _____ Relationship _____
Address _____ Telephone _____
5. What was your profession or occupation? _____
6. With whom are you now living? _____
7. Have you made application for admission to any other home or institution? _____
If yes, please give name _____
8. Describe your general health condition _____

What serious illnesses have you had in the past five years? _____

9. Name of your physician _____

10. In case of death or serious illness, the first to be notified should be:
 Name _____
 Address _____
 Home Telephone _____ Work Telephone _____
11. Religious affiliation _____
 Church Name _____
 Pastor _____
12. Health Insurance Information:
 Medicare Health Insurance claim number: _____
 Medicare Part A, Hospital Insurance Yes _____ No _____
 Medicare Part B, Medical Insurance Yes _____ No _____
 Medicare Advantage Plan Yes _____ No _____
 Long-term Care Insurance (state company and policy number)

 Do you have an open automobile or accident claim Yes _____ No _____
 Other Hospital/Medical Insurance (state company and policy number)

13. Burial Arrangements: Place of Internment _____
 _____ Lot Number _____
 Holder of the deed _____
 Name of Funeral Director _____
 What financial arrangements have been made for funeral expenses?

 Please list amount set aside for burial _____
14. What type of accommodations are you requesting?
 Semi-private _____ or Private _____
15. Do you smoke? Yes _____ No _____
16. I was referred to The Shook Home by:
 a. Physician _____ b. Hospital Social Services _____
 c. Newspaper _____ d. Radio _____
 e. Television _____ f. Friend _____
 g. Attorney _____ h. Another Shook Home Resident _____
 i. Trust Officer or Bank Personnel _____
 j. Other, please list _____

17. Financial Data Available to Provide for Care of the Resident

<u>Assets</u>		<u>Liabilities</u>	
Value of Real Estate	\$ _____	Real Estate Mortgage	\$ _____
Investments	\$ _____	Notes Owned	\$ _____
Savings Account	\$ _____	Other Debts	\$ _____
Other	\$ _____		
TOTAL ASSETS	\$ _____	TOTAL LIABILITIES	\$ _____

Regular monthly income

Social Security	\$ _____
Pension or Retirement income	\$ _____
Rentals	\$ _____
Investments	\$ _____
Other	\$ _____
TOTAL MONTHLY INCOME	\$ _____

Has applicant been a resident in another ECF within last 60 days: ____ Yes ____ No

If so, which one? _____

Have any assets been transferred in the last 5 years: ____ Yes ____ No

If yes, list asset and date of transfer _____

Who is financially responsible for paying your bills? _____

Do you have a power-of-attorney to act on your behalf? Yes ____ No ____

If so, please name that person: _____

Life Insurance: Yes ____ No ____ Face Value _____

Company _____ Policy Number _____

If required, would you be willing to furnish a more detailed financial statement?

Yes ____ No ____

18. The applicant understands that it is the policy of the Home to admit and care for individuals without regard to race, color, national origin, ancestry, age, sex, religious creed or disability.
19. The applicant, by signing hereunder, affirms that all statements, answers, and other representations provided herein are true.

Signature _____ Date _____

Upon receipt of completed application, the applicant's name will be placed on the waiting list. Applicants may inquire as to their status on that list at any time. If an applicant no longer desires admission, kindly advise The Shook Home.

Please attach to this application a copy of your durable power of attorney, living will or advanced medical directive, insurance cards and social security card.

Shook Home Pre Screening Instrument
Personal Care

Name:

Birthdate:

Social Security Number:

Exclusionary Factors

(Place a ✓ in appropriate boxes if it applies)

Totally and permanently confined to bed	_____
Non-Self-Care, Gastrointestinal feedings	_____
Third Stage or Multiple Decubiti (Bed Sores)	_____
Naso-Gastric feedings	_____
Intravenous Fluids	_____
Restraints	_____
Has been assessed medically at a higher level of care	_____

Precautionary Factors

(Place a ✓ for what applies)

Full Assistance with meals	_____
Non-Self-Care oxygen	_____
Incontinent of bowel	_____
Incontinent of Bladder	_____
Catheter care	_____
Oxygen monitoring	_____
Tracheotomy monitoring	_____
Non-Self-Care Inhalation Therapy	_____
Colostomy monitoring	_____
Special Skin Care & Precautions	_____
Unaware of Unsafe Areas	_____
Tends to Wander, may get lost	_____
Requires 24 hour awake supervision	_____

Personal Care Service Needs
(Place a ✓ for each service needed)

“Supervised Care”

Oversight & Supervision _____
 Tasks of daily Living _____
 Appointment Assistance _____
 Social & Leisure Activities _____
 Securing Health Care _____
 Use of Prosthetic Devices _____

“Personal Hygiene”

Bathing _____
 Oral Hygiene _____
 Hair Care _____
 Dressing/Care of Clothes _____

“Shopping”

Care of Possessions _____
 Use of Telephone _____
 Correspondence _____
 Personal Laundry _____
 Ambulation _____
 Securing Transportation _____

“Medication”

Assist with Self Administration _____
 Remembering Schedule _____
 Storing Medication _____
 Insulin Injection _____

Mobility Assessment

(Please check appropriate level)

Mobil – Physically & Mentally capable of independently vacating the home,
 Including ascend & descend stairs if in the path of the exit. _____

Mobil – Capable of vacating the home with limited assistance including ascending
 and descending the stairs if in the path of the exit. _____

Immobile – Capable of vacating the home with continual and full assistance of
 Others _____

Signature _____

Date _____