



**THE ARBORS
AT ST. BARNABAS**

85 CHARITY PLACE
VALENCIA, PA 16059
724-625-4000, EXT. 258

ADMISSION FORM

Date Received _____

Date Admitted _____

Resident Name _____ Phone _____

Address _____ City _____ ST _____ ZIP _____

Birthplace _____ Birthdate _____

(mo) (day) (year)

Sex: M _____ F _____ Single _____ Married _____ Widowed _____ Divorced _____

Soc. Sec. No. _____ Medicare No. _____ Medicaid No. _____

Secondary Insurance Plan Name _____ I.D.# _____

Prescription Drug Plan Name _____ I.D.# _____

Former Occupation _____ Military: Enlisted _____ Discharge _____

Last Employer _____ Veteran Claim No. _____

Termination Date _____ Serial No. _____

Primary Contact:

Name (Last) (First) Telephone No. Relationship

Address City State ZIP

Secondary Contact:

Name (Last) (First) Telephone No. Relationship

Address City State ZIP

Tertiary Contact:

Name (Last) (First) Telephone No. Relationship

Address City State ZIP

GENERAL INFORMATION

Have you resided in any other Home or Institution? _____ Dates _____

Name _____ Address _____

Nature and onset of illness _____ Date _____

Mental Status _____ Bedfast _____ Confined to wheelchair _____

Do you smoke? _____ Drink? _____

Who will take care of burial arrangement? _____

Who will pay funeral expenses? _____

Funeral Director to be notified _____

Has a will been made? _____ Where can it be located? _____

Who is responsible for your personal belongings? Name _____

Address _____

Is life insured? _____ Who pays premium? _____

Insurance Company _____ Beneficiary _____

Give name, address, and phone number of Executor and Attorney _____

Primary Care Physician _____ Phone _____

Name P.O.A. Financial/Relationship _____

Name P.O.A. Healthcare/Relationship _____

FINANCIAL STATEMENT

ASSETS & ANNUAL INCOME

Value as of _____
(date)

	\$ Value of Asset	Annual Income from Asset
Real Estate		
Residence _____	\$ _____	\$ _____
Cash: Savings _____	\$ _____	\$ _____
CDs _____	\$ _____	\$ _____
Money Market Accts. _____	\$ _____	\$ _____
Marketable Securities:		
Stocks _____	\$ _____	\$ _____
Bonds _____	\$ _____	\$ _____
Mut. Funds _____	\$ _____	\$ _____
Proceeds from Life Ins. _____	\$ _____	\$ _____
(Complete page 4)		
Cash Surrender Value of Ins. _____	\$ _____	\$ _____
Trust and Custodial Accounts _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Identify Source(s)		
TOTALS	\$ _____	\$ _____

DEBTS

Owed As Of _____

(date)

Amount Owed

SECURITY (If Any)

OWED TO:

Bank _____ \$ _____
Name of Bank

Bank _____ \$ _____
Name of Bank

Mortgage _____ \$ _____
Name of Lender

Mortgage _____ \$ _____
Name of Lender

Credit Card VISA _____ \$ _____

Credit Card MASTERCARD _____ \$ _____

Credit Card DISCOVER _____ \$ _____

Credit Card AMERICAN EXPRESS _____ \$ _____

Credit Card _____ \$ _____

Credit Card _____ \$ _____

Finance Company _____ \$ _____
Name of Lender

Other _____ \$ _____
Name of Lender

FINANCIAL REFERENCES

Bank _____ Name _____ Address _____

Bank _____ Name _____ Address _____

Trust Co. _____ Name _____ Address _____

Other _____ Name _____ Address _____

ANNUAL INCOME:

Social Security:
First Person Monthly SS \$ _____ \$ _____
Second Person \$ _____ \$ _____

Pension (First Person)
Fixed As to Amount _____ \$ _____

Increases with COLA _____ \$ _____
Source of Pension

Source of Pension

Pension (Second Person)
Fixed As to Amount _____ \$ _____

Increases with COLA _____ \$ _____
Source of Pension

Source of Pension

Other Recurring Income _____ \$ _____
Source of Other Income

Source of Other Income

Other Recurring Income _____ \$ _____
Source of Other Income

Source of Other Income

TOTAL ANNUAL INCOME \$ _____

ROUTINE EXPENSES

• Average Cost of Monthly Medications \$ _____

Does Applicant have an active PACE Card? YES NO
(Circle One)

• Apartment for Housing Rent \$ _____
Rent Obligation Ends _____
(Date)

• Monthly Supplemental Insurance Payments \$ _____
(Medicare Part B, Blue Cross/Blue Shield, etc.)*

• Life Insurance Payment* \$ _____

• Long Term Care Policy Payment* \$ _____

Other (Please Specify) _____

* If payment is quarterly, divide quarterly payment by 3 to determine monthly amount.

TOTAL MONTHLY ROUTINE EXPENSES \$ _____

Do you give St. Barnabas Health System permission YES NO
to run a credit report? (Circle One)

These are my assets, debts, liabilities and sources of income as of _____
(Date)

Signature of Applicant/Date

Signature of Power of Attorney/Date