

United Church of Christ Homes

Ephrata Manor

Thornwald Home

Kindred Place

Sarah A. Todd Memorial Home

The Lebanon Valley Home

APPLICATION FOR ADMISSION

ALL Applicants complete the following pages:

Biographical and Insurance Information: pages 1

Community & Service Interests: page 2

Financial Information: pages 3 and 4

Personal Information: page 6

Nursing and Personal Care Applicants complete additional:

Medical Information: page 5 [unless admitted directly
from the hospital or other
healthcare facility]

The information requested on these forms is needed to evaluate the applicant for admission.
Please complete to the best of your ability. All information will be kept confidential.

Name _____ Date _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email Address _____ Social Security Number _____

Date of Birth _____ Sex: Male Female

Marital Status: Single Married Widow/er Divorced Separated

Name of Spouse _____

Insurances: *(Copies of all cards are required)*

Medicare: _____ MBI#: _____
Part A Yes No Part B Yes No

Medical Assistance # _____

Health Insurance Provider _____

Policy # _____

Part D Prescription Drug Provider _____

Policy # _____

Long Term Care Insurance Provider _____

Policy # _____

Admission Application: Community and Service Interests

Is there any special date by which you desire to enter the Community? _____

Check Preferred Location

Check Preferred Accommodation

Ephrata Manor
99 Bethany Road
Ephrata, PA 17522
(717) 738-4940

Apartment
Personal Care and Residential Living
Nursing Care

The Lebanon Valley Home
550 East Main Street
Annville, PA 17003
(717) 867-4467

Cottage
Personal Care and Residential Living
Nursing Care

Thornwald Home
442 Walnut Bottom Road
Carlisle, PA 17013
(717) 249-4118

Personal Care and Residential Living
Nursing Care

Kindred Place at Annville
One Kindred Place
Annville, PA 17003
(717) 867-5572

Apartment

Kindred Place at Harrisburg
4700 Oakhurst Blvd.
Harrisburg, PA 17110
(717) 657-7900

Apartment

Sarah A. Todd Memorial Home
1000 West South Street
Carlisle, PA 17013
(717) 245-2187

Apartment
Cottage
Nursing Care

With regard to admission and services, it is the policy of United Church of Christ Homes to operate each of its communities and programs, and provide services without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness, or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals.

Admission Application: Financial Information

Applicant Name: _____

Income/Assets Available for Applicants' Care	Applicant	Spouse	*	Not Verified	Explanation
<i>Income</i>					
Monthly Social Security/SSI			*		
Monthly Pensions			*		
Monthly Annuities			*		
Monthly Rental Income			*		
Other (list):			*		
			*		
			*		
<i>Assets Available for Applicants' Care</i>					
Savings & Checking Accounts			*		
Investments			*		
Certificates of Deposit			*		
Home			*		
Other Properties			*		
Automobile					
Life Insurance					
IRA's/Retirement Accounts			*		
Other (list):			*		
			*		
			*		
<i>Liabilities</i>					
Credit Card Debt			*		
Home Mortgage or Reverse Mortgage			*		
Loans			*		
Notes			*		
Other Debt (list):					
			*		
			*		

* Please attach verification of requested information.

Verification of information will be required in order to complete application.

Name of person completing information: _____

Admission Application: Medical Information

Applicant Name _____

Applicant Information **(Nursing & Personal Care Applicants Only, unless coming from the hospital or other healthcare facility)**

Are you capable of caring for your personal needs: bathing, dressing, walking, eating? Yes No
 If no, please explain: _____

What support and safety measures do you use? Cane Walker Wheelchair
Hearing Aid Glasses

Special Dietary Needs: _____
 Allergies: _____

Have you completed a Living Will? Yes No *If Yes, please provide a copy.*

Do you have a POLST? Yes No *If Yes, please provide a copy.*

Do you have an Out of Hospital
 DO NOT RESUSCITATE Order? Yes No *If Yes, please provide a copy.*

Signature of person completing information: _____

Physician Evaluation

Height _____ Weight _____ BP _____ Pulse _____

Is Applicant free of infectious disease? Yes No Date/result last chest x-ray _____

Immunization Hx: Flu _____ Pneumovax _____ TB _____ COVID _____ *(Please provide copy of cards)*

Is Applicant physically restricted in any way? _____

*Is there any history of substance abuse? (i.e. cigarettes, nicotine, alcohol, illegal or RX drugs)

Is there any history of mental illness? If yes, please explain _____

Drug Allergies: _____

	MNL	ABN	Description - Abnormalities
Skin			
Eyes			
ENT			
Lungs			
Heart			
Breast			
Abdomen			
Back			
Genitalia, Rectal			
Extremities			
Neurological			
Orientation, Memory			

Major Diagnoses:

Additional Comments:

Please attach current medications and dosages and any additional information you feel would be helpful in determining Applicant's needs and our ability to meet those needs.

Physician Signature _____ **Date** _____

**This question is only asked to have a full understanding of care that may be required and will not be the sole deciding factor when it comes to admissibility.*

Admission Application: Personal Information

Applicant Name _____

Names of ALL Living Children: (if none, list three nearest relatives)

RELATIONSHIP	NAME	CITY/STATE	HOME TEL #	WORK TEL#	CELL #

Responsible Party Name _____ Home # _____
Address _____ Work # _____
_____ Cell # _____

E-mail Address _____

1st Emergency Contact _____ Home# _____ Work # _____ Cell # _____
2nd Emergency Contact _____ Home# _____ Work # _____ Cell # _____

Veteran Yes No Active duty dates _____ (year) to _____ (year)
Spouse of a Veteran Yes No

Optional Information

Church Membership _____ City/State _____

Pastor's Name _____ Telephone # _____

Previous Occupation(s)