INGLIS HOUSE

2600 Belmont Avenue
Philadelphia, PA 19131
215-878-5600 Fax: 215-878-7611

Date:_____

ADMISSION APPLICATION

Applicant's Name: _____ Home Phone: _____

Address: _____

DOB: _____ Sex: _____ Religion: _____ Marital Status*: _____
If divorced, please attach a copy of divorce decree

Social Security Number: _____

Copies of ID (State Driver License, Social Security Card, Birth Certificate, etc) &
Copies of Insurance Cards (Including Medicare Card & Access Cards) must be attached to application.

Medicare Number: _____ Part A ☐ Part B ☐

Medicare D: Yes ☐ No ☐ Plan Name: _____ Effective: _____

Medicare HMO: _____ Policy # _____

Supplement Insurance: _____ Policy # _____

Other Insurance: _____ Policy # _____

Has applicant ever been in another nursing center? Yes _____ No _____

If yes, please list the nursing center and dates of stay: _____

Does the applicant smoke? Yes/No _____

Primary Contact Information:

Primary Contact Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Other persons to contact in case of an emergency:

Name	Relationship	Address	Phone Number

MEDICAL AND PERSONAL DATA

Primary Diagnosis _____Age of Onset_____

Secondary Diagnosis _____

Primary Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

Is the applicant aware of the placement decision? Yes ☐ No ☐
Is there an Advance Directives or Living Will? Yes ☐ No ☐
Has the applicant made pre-paid funeral arrangements? Yes ☐ No ☐

Funeral Home preference: _____ Phone Number: _____

HOSPITALIZATIONS

Please list ALL hospitalizations within the last two years, including any psychiatric and drug/alcohol treatment centers

Facility Name	Address	Dates	Reason

Please indicate any special needs, requirements or equipment the applicant has or will need.

Is the applicant a smoker? Please circle and comment: Never Have Smoked

YES- How many a day?

_____

Quit – How long ago?

_____

FINANCIAL INFORMATION

To process your application, the following information is needed. The information supplied is strictly confidential and allows us to assist you in the financial planning of the Resident's care. The financial data should be that of the applicant. Your cooperation is appreciated in order to expedite admission.

The name(s) of the person(s) who will be responsible for facilitating payment:

Name Address Home/office phone Relationship

_____

_____

_____

Responsible Party Signature:

_____

Does the applicant have any of the following?

Trust Account: _____ Yes _____ No _____

Legal Guardian: _____Yes _____ No _____

Power of Attorney: _____ Yes _____ No _____

If yes, DOCUMENTATION of Trust, Guardianship, or Power of Attorney is required.

MONTHLY INCOME:	**AMOUNT:**
Salary	_____
Social Security (**Please attached a SS Letter**)	_____
Pensions/Annuities	_____
IRA	_____
Interest/Dividend Income	_____
Veteran's Benefits	_____
Alimony	_____
Other	_____
TOTAL MONTHLY INCOME	_____

Please use this space for any comment on the above financial information:

_____

_____

_____

ASSETS*:

	Bank Name/Location	Account #	Balance
Cash	_____	_____	_____
Checking	_____	_____	_____
Saving	_____	_____	_____
Other	_____	_____	_____
Securities	_____	_____	_____

*** Please provide copies of assets, including bank statements for the last three months. This information is required to determine eligibility under state payment plans. Be aware that the state may ask for information as far back as five years.**

Real Estate (Description/Location) & Address

_____ $ _____

_____ $ _____

Jointly Owned? Yes ☐ No ☐ Name of Co-Owner _____

Is anyone currently living in this home? Yes ☐ No ☐

If yes; Name/ Relationship: _____

_____

Is the applicant planning to return to the home at completion of treatment plan? Yes ☐ No ☐

Is the real estate currently for sale, or is there intent to sell within the next 12 months? Yes ☐ No ☐

OTHER ASSETS:

1. Cash Value of Life Insurance $ _____

2 Vested Pension Benefits $ _____

3. Business Interests $ _____

4. Automobiles $ _____

5. Funeral Account (If not irrevocable trust) $ _____

6. Other $ _____

TOTAL ASSETS (A): $ _____

Please use this space for any comment on the above assets:

_____

_____

LIABILITIES

Home Mortgage $ _____

Credit Cards/Charge Accounts $ _____

Loans $ _____

Other Personal Debts $ _____

Medical Expenses $ _____

Tax Owned/Liens $ _____

TOTAL LIABILITIES (B): $ _____

NET WORTH (*Subtract Line B from Line A*) $ _____

Please provide the appropriate statements/documentation to support the above financial data.

Does the applicant currently receive Medicaid benefits in the community?

Yes ☐ No ☐ If yes, Medicaid # _____ Effective Date: _____

Has an application for Medicaid Long Term Care Benefits been initiated?

Yes ☐ No ☐ If yes, Case Worker's Name _____ Telephone#_____

Has an application for Medicaid for Long Term Care Benefits been denied?

Approved _____ Date_____ Medicaid # _____

Denied _____ Date _____ Reason _____

I herby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that the Facility will rely upon the accuracy and completeness of the information in making an admission decision, and if any information has been falsely represented, this will be sufficient cause for voiding my application for admission. In addition, I understand that the Facility will rely upon the accuracy and completeness of the financial information to determine the applicant's responsibility for private payments or eligibility for benefits under government or commercial insurance programs. I understand that I must notify the Facility in writing of any substantial change in financial condition. All of the information will be kept confidential.

Signature of Applicant and/or Responsible Party:

Signature: _____ Date: _____

Signature of Facility Representative (if presently residing in a Assisted Living or Nursing Facility):

Signature: _____ Date: _____

NOTE: The Physician's Medical Report on the next four pages is to be filled out by your physician. This report must be returned with the application.

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PHYSICIAN'S MEDICAL REPORT

NAME				DATE OF BIRTH	
HEIGHT	WEIGHT	BP	HR	RESP	TEMP

HOSPITALIZATIONS IN THE PAST 6 MONTHS [ ] Yes [ ] No If Yes, please list dates, hospital and reason for hospitalization

ALLERGIES [ ] Yes [ ] No If Yes, please list all known allergies

DIETARY RESTRICTIONS [ ] Yes [ ] No If Yes, please list all restrictions

IMMUNIZATIONS [ ] Yes [ ] No If Yes, please list all & most recent dates

MEDICATIONS [ ] Yes [ ] No If Yes, please list all medications

MEDICATION	DOSE / FREQUENCY	PSYCHOTROPIC MEDICATION	DOSE / FREQUENCY

PHYSICIAN'S MEDICAL REPORT

PHYSICAL EXAMINATION PLEASE PROVIDE ADDITIONAL INFORMATION FOR ALL ABNORMAL ITEMS

EYES	**[ ] NORMAL**	**[ ] ABNORMAL**	
EARS	**[ ] NORMAL**	**[ ] ABNORMAL**	
NOSE	**[ ] NORMAL**	**[ ] ABNORMAL**	
THROAT	**[ ] NORMAL**	**[ ] ABNORMAL**	
MOUTH	**[ ] NORMAL**	**[ ] ABNORMAL**	
NECK	**[ ] NORMAL**	**[ ] ABNORMAL**	
SKIN	**[ ] NORMAL**	**[ ] ABNORMAL**	
LUNGS	**[ ] NORMAL**	**[ ] ABNORMAL**	
HEART	**[ ] NORMAL**	**[ ] ABNORMAL**	
ARTERIES	**[ ] NORMAL**	**[ ] ABNORMAL**	
VEINS	**[ ] NORMAL**	**[ ] ABNORMAL**	
ABDOMEN	**[ ] NORMAL**	**[ ] ABNORMAL**	
HERNIA	**[ ] NORMAL**	**[ ] ABNORMAL**	
GYNECOLOGICAL	**[ ] NORMAL**	**[ ] ABNORMAL**	
GENITALIA (MALE)	**[ ] NORMAL**	**[ ] ABNORMAL**	
ANAL / RECTAL	**[ ] NORMAL**	**[ ] ABNORMAL**	
NERVOUS SYSTEM	**[ ] NORMAL**	**[ ] ABNORMAL**	
OTHER (PLEASE SPECIFY)	**[ ] NORMAL**	**[ ] ABNORMAL**	

COMMUNICABLE DISEASES [ ] Yes [ ] No If Yes, please specify disease/diagnosis and list the precautions needed to ensure the safety of other residents and staff. Please note immunizations also.

FALL RISK [ ] Yes [ ] No If Yes, please list fall precautions presently in place

ASSISTIVE DEVICES [ ] Yes [ ] No If Yes, please specify devices used

PHYSICIAN'S MEDICAL REPORT – FUNCTIONAL LEVEL

NAME	DATE OF BIRTH

BED MOBILITY How an applicant moves to and from a lying position, turns side to side, and positions body while in bed.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
TRANSFERS How applicant moves to and from bed, chair, wheelchair, standing.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
EATING How an applicant eats/drinks regardless of skill (includes G-tube).	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
TOILET USE How applicant uses the toilet room/ commode/bedpan/urinal.	[ ] Independent [ ] Limited Assistance [ ] Extensive Assistance [ ] Total Dependence
BLADDER FUNCTION	[ ] Continent [ ] Incontinent >>> [ ] Occasional [ ] Daily Foley Catheter [ ] Yes [ ] No Supra Pubic Catheter [ ] Yes [ ] No Ostomy [ ] Yes [ ] No
BOWEL FUNCTION	[ ] Continent [ ] Incontinent >>> [ ] Occasional [ ] Daily Constipation [ ] Yes [ ] No History of Impaction [ ] Yes [ ] No Uses Suppository [ ] Yes [ ] No Ostomy [ ] Yes [ ] No Type: _____ Colostomy [ ] Yes [ ] No
MOBILITY	[ ] Ambulatory [ ] Wheelchair – Powered [ ] Cane/Walker [ ] Wheelchair – Manual
SPEECH	[ ] Unimpaired [ ] Mild Difficulty [ ] Aphasic
MEMORY	[ ] Intact [ ] Impaired Short Term [ ] Impaired Long Term
MENTAL STATUS	[ ] Clear [ ] Occasionally Confused [ ] Confused

MENTAL HEALTH HISTORY Please provide additional information	**HISTORY OF SUICIDAL ATTEMPTS** [ ] Yes [ ] No If Yes, please provide additional information

PHYSICIAN'S MEDICAL REPORT – DIAGNOSIS INFORMATION

NAME	DATE OF BIRTH

PLEASE CHECK [✓] ALL DIAGNOSES THAT APPLY	Please List Additional Diagnoses Below
[ ] Comatose	
[ ] Cerebral Palsy	
[ ] Multiple Sclerosis	
[ ] Paraplegia	
[ ] Quadriplegia	
[ ] TBI	
SPINA BIFIDA	
[ ] Spina bifida with hydrocephalus-cervical region (741.01)	
[ ] Spina bifida with hydrocephalus-dorsal region (741.02)	
[ ] Spina bifida with hydrocephalus-lumbar region (741.03)	
[ ] Spina bifida with hydrocephalus – NOS (741.00)	
[ ] Spina bifida (w/o mention of hydrocephalus) (741.90)	
[ ] Spina bifida-cervical region w/o mention of hydrocephalus (741.91)	
[ ] Spina bifida-dorsal region w/o mention of hydrocephalus (741.92)	
[ ] Spina bifida-lumbar region w/o mention of hydrocephalus (741.93)	
[ ] Spina bifida occulta (756.17)	
SPINAL CORD INJURY	
[ ] Spinal cord injury NOS (952.9)	
[ ] Spinal cord injury at birth (767.4)	
MUSCULAR DYSTROPHY	
[ ] Hereditary progressive muscular dystrophy (359.1)	
[ ] Congenital hereditary muscular dystrophy (359.0)	
ENCEPHALOPATHY	
[ ] Encephalopathy NOS (348.3)	
[ ] Metabolic encephalopathy (348.31)	
[ ] Toxic encephalopathy (349.82)	
OTHER DIAGNOSES	
[ ] Late effect cerebral aneurysm, including hemiplegia (438.20)	
[ ] Anoxic brain damage (348.1)	
[ ] Friedeich's ataxia (334.0)	
[ ] Myositis ossificans progressive (728.11)	
[ ] Charcot-Marie-Tooth disease (356.1)	
[ ] Amyotrophic sclerosis (335.20)	
[ ] Primary lateral sclerosis (335.24)	
[ ] Spinal curvature - NOS in other disease (737.40)	
[ ] Cerebellar ataxia (334.3)	
[ ] Dystonia musculorum progressive (333.6)	
[ ] Cerebral degeneration (331.7)	
[ ] Huntington's chorea (333.4)	
[ ] **None of the Above Diagnoses Apply**	

NAME OF PHYSICIAN (PLEASE PRINT)

ADDRESS

PHONE NUMBER(S)

PHYSICIAN'S SIGNATURE:	DATE: