POCOPSON HOME
APPLICATION FOR ADMISSION

_____ Adm Date
_____ Med Rec #
_____ Room #
_____ Time

PLEASE COMPLETE ALL SECTIONS
QUESTIONS SHOULD BE DIRECTED TO THE ADMISSIONS OFFICE
TELEPHONE: 610-793-1212 FAX: 610-793-2493

SOCIAL HISTORY

Name:_____ ☐Male ☐ Female Maiden Name:_____
(As shown on Medicare Card)

Address:_____

Marital Status:_____ Age:_____ Birthdate:____/____/_____ Birthplace:_____

Citizen of:_____ Naturalization Date & No._____

Religion_____ Former Occupation:_____

Former Employer:_____

Military Status: ❑ Veteran ❑ Widow/Spouse Veteran Claim #_____ Branch:_____

Date Entered: _____ Date Discharged:_____

Name of Spouse(s)_____ Spouse's Birthdate ____/____/_____

Spouse's Address:_____
If Deceased, List Date of Death If Divorced, List Date of Divorce

Persons to Notify in Case of an Emergency:

1. _____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

2. _____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

3. _____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

4. _____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

5. _____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

Living Will/Advance Directive for Healthcare? Yes ☐ No ☐
Durable Power of Attorney? Yes ☐ No ☐
Court Appointed Guardian? Yes ☐ No ☐

Please provide corresponding documents with submission

_____
Name Relationship Address
_____
Home Telephone Number Work Telephone Number Cell Telephone Number

Would you like to provide your email address? _____

Names of Previous Facilities (hospitals, nursing homes, rehabs) that Applicant has been admitted to within the past year.

Name of Facility	Date Admitted	Date Discharged
Name of Facility	Date Admitted	Date Discharged
Name of Facility	Date Admitted	Date Discharged
Name of Facility	Date Admitted	Date Discharged

MEDICAL INSURANCE

Social Security Number: __ __ __ - __ __ - __ __ __ __

Medicare Number: __ __ __ - __ __ - __ __ __ __ ___

Please provide copies of all documented insurance cards

Hospital Benefits Effective:_____

Medical Benefits Effective:_____

List Other Medical Insurance

Name of Insurance:_____ HMO? Yes ❑ No ❑

ID #:_____ Group #_____ Plan_____

Amount Last Paid Premium: $_____ How Often Paid:_____

Access Card (Medical Assistance): Recipient #:_____

Member of a Prescription Drug Program? Yes ❑ No ❑

Name of Company:_____ Policy #:_____

MONTHLY INCOME

	APPLICANT	SPOUSE		APPLICANT	SPOUSE
Social Security	$	$	Disability or SSI	$	$
Pension(s)	$	$	Trust Payments	$	$
Veterans Benefit (A & A)	$	$	Annuity	$	$
Railroad Retirement	$	$	Other Income	$	$

Please indicate where each check is sent:_____

_____

_____

LIFE INSURANCE/FUNERAL ARRANGEMENTS **(If married, include information about spouse).**

If total face value(s) of all life insurance policies exceed $1,500.00, please include cash value(s).

COMPANY	ISSUE DATE	POLICY #	TYPE	OWNER OF POLICY	FACE VALUE(S)	CASH VALUE(S)	PAID UP OR PREMIUM AMOUNT

Prearranged and/or Prepaid Burial Contracts **(If married, include information about spouse).**

BANK/FUNERAL HOME	DATE SET UP	AMOUNT

(All Prepaid Burial Arrangements Must Be Irrevocable)

Funeral Director:_____

Name of Cemetery:_____

Cremation: Yes ❑ No ❑ Donor of Organs Card: Yes ❑ No ❑

Humanity Gift Registry: Yes ❑ No ❑
(Body donation to Medical School)

PROPERTY

Does applicant presently own any property? (Residential or Nonresidential) Yes ❑ No ❑

If yes, address:_____

Township:_____ Monthly Mortgage: $_____

Name(s) on Deed:_____

Has applicant sold or transferred any property (residential or nonresidential) within the past 5 years? Yes ❑ No ❑

If yes, address:_____

Selling Price: $_____ Date Sold:_____

ASSETS **List *all* assets (solely & jointly) owned. (If married, include information about spouse).**

TYPE OF ACCOUNT	NAME OF BANK	ACCOUNT NUMBER	ACCOUNT HOLDER'S NAME	CURRENT BALANCE	DATE
Checking Account(s)					
Savings Account(s)					
Savings Bonds					
Certificate of Deposits					
Stocks/Mutual Funds					
Money Market Accounts					
Cash On Hand					
Trust Funds					
Retirement Accounts (IRA)					
Other					

List all outstanding bills (medical, credit cards, etc.):_____

_____

_____

_____

Motor Vehicles (If married, list all vehicles)

Owner:_____

Year:_____

Make & Model:_____

Amount Owed: $_____

Mobile Home

Owner:_____

Location:_____

Residential ❑ Income Producing ❑

Year:_____ Lot Fee: $_____

In the past 5 years, has applicant and/or spouse closed, given away, sold, transferred or received less than fair market value for any assets such as: A home, land, personal property, life insurance policies, annuities, bank accounts, CDs, stocks, IRAs, bonds, or a right to income? Yes ❑ No ❑

Type of resource(s):_____

Market Value at time of Transfer: $_____ Date of Transfer/Closing:_____

Explain Circumstances:_____

_____

_____

_____

I understand that the information supplied is correct and that fraudulent attempts to conceal or ignore material facts may result in possible legal proceedings by the Department of Public Welfare and/or Pocopson Home in order to recoup any assets or income inappropriately transferred.

_____ _____

Date Application Signature of Person Completing This Document / Relationship

PRINT

Completion of this Application Does Not Guarantee Approval for Admission.

For Pocopson Home Use Only

Options Assessment:_____ ***PA600L Status:***_____ ***Payor Source:***_____