Berks Heim Nursing and Rehabilitation
Long-term Care Admissions Application

Personal Information

Full Name: _____ Preferred Name: _____

Address: _____
City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Cell: _____

Applicant is currently at: ☐ Home ☐ Personal Care/Assisted Living: _____
☐ Nursing Facility: _____ ☐ Hospital: _____

Current Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Social Security Number _____ Primary Language(s): _____

Religious Affiliation: _____ Church/Temple Name: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

Place of Birth: _____ Marital Status: _____

Maiden Name or other Alias: _____ Veteran: ☐ Yes, branch: _____ ☐ No

Education: _____ Occupation: _____

Primary Contacts

1. Name: _____ Relationship: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Home Phone: _____ Work Phone: _____Cell Phone: _____
   Email Address: _____
2. Name: _____ Relationship: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Home Phone: _____ Work Phone: _____Cell Phone: _____
   Email Address: _____
3. Name: _____ Relationship: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Home Phone: _____ Work Phone: _____Cell Phone: _____
   Email Address: _____

This center is not responsible for burial preparation and expenses.

Funeral Home: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Prepaid Arrangement ☐ Irrevocable Burial Fund Amount: $_____

Primary Physician: _____ Phone: _____

Elder Law Attorney: ☐ Yes _____ Phone: _____ ☐ No

Please list power of attorney* or legal guardian* appointed to manage your affairs and check the type:

☐ Financial & Medical
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Cell Phone: _____
Email Address: _____

☐ Financial Only
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Cell Phone: _____
Email Address: _____

☐ Medical Only
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Cell Phone: _____
Email Address: _____

☐ Court-appointed Legal Guardian
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Cell Phone: _____
Email Address: _____

*At time of admission, submit a copy of the legal document.

Does applicant have a living will? ☐ Yes ☐ No

Health Insurance & Prescription Drug Coverage

Complete all that apply:

Coverage	Name	Policy Number
Medicare		
HMO/PPO/POS (Managed Care Plan or Medicare Supplement		
Long-term Care Insurance		
Prescription Drug Plan		

Submit copies of all insurance cards and long-term care policies as soon as possible.

Financial Information

Please list monthly income from all sources:

Social Security $ _____

Pension $ _____ Source: _____

Annuity $ _____ Source: _____

Interest $ _____

Dividends $ _____

Veterans Benefit $ _____

SSI Benefit $ _____

Other $ _____ Source: _____

Please list cash assets from savings accounts, checking accounts, certificates of deposit (CD's), money market funds, etc.:

Institution	Type of Account	Amount	Ownership
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint

Life Insurance Company	Face Value	Cash/Surrender Value
		$
		$
		$
		$

Please list any stocks, bonds or mutual funds held:

Institution	Type of Account	Current Value	Ownership
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint
		$	☐ Single ☐ Joint

Real Estate:

Primary Home Address	Assessed Value	Estimated Value	Ownership
	$	$	☐ Single ☐ Joint

Are there any liens against this property? ☐ Yes ☐ No

If yes, type of lien: ☐ First Mortgage Amount: $_____
☐ Home Equity Amount: $_____
☐ Reverse Mortgage Amount: $_____

Does anyone currently live in the applicant's primary residence: ☐ Yes ☐ No

Name	Relationship

Other Real Estate Address	Assessed Value	Estimated Value	Ownership
	$	$	☐ Single ☐ Joint
	$	$	☐ Single ☐ Joint
	$	$	☐ Single ☐ Joint

Are there any liens against this property? ☐ Yes ☐ No

Property: _____ Name: _____ Amount: $_____

Property: _____ Name: _____ Amount: $_____

Have you given away, or transferred any money, stocks, bonds, personal property, real estate, mortgages or anything else of value during the last five years? ☐ Yes ☐ No

Asset	Transferred to Whom	Date of Transfer	Amount/Value:
			$
			$
			$

Does the applicant own any other assets? (vehicles, etc.)

Asset	Estimated Value
	$
	$
	$

Background Information

Is the applicant aware of the pending nursing home placement? ☐ Yes ☐ No

Has applicant ever been convicted of a felony? ☐ Yes ☐ No

Concerns with placement: ☐ Yes ☐ No Concern: _____

Clutter/hoarding: ☐ Yes ☐ No Signs of infestation: ☐ Yes, _____ ☐ No

Current use or history of: Drugs ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No Nicotine: ☐ Yes ☐ No
If yes indicated, explain: _____

Current or history of: Wandering/exit seeking: ☐ Yes ☐ No Combative: ☐ Yes ☐ No
Other: _____

Any signs of infection (Respiratory, GI, ENT, jaundice, rash, wounds, fever, diarrhea, chills and/or cough):
☐ Yes, _____ ☐ No

Vaccinations:

Vaccination	Date	Vaccination	Date
COVID-19 Booster		Pneumovax (23)	
Flu		Prevnar13	
Measles <60			

☐ I am interested in receiving information on recommended vaccinations.

***Per Pennsylvania Pre-Admission Screening Resident Review Regulations:**

Does applicant have:

Any condition that caused intellectual disability, prior to the age of 18? ☐ Yes ☐ No

Circle **any diagnosis of:** Dementia, Depression, Schizophrenia, Bipolar, Brain Injury, Huntington's Disease and/or PTSD.

Seizures before the age of **22?** ☐ Yes ☐ No

Any Mental Health Case Manager (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTI) or Assertive Community Treatment (ACT)? ☐ Yes ☐ No

In past 2 years, please circle: Admission to a **State Hospital,** Treatment in a **Psychiatric facility,** Treatment in a Partial Psychiatric Day Program, A Stay in a Long-term Structured Residence, Receive Electroconvulsive Treatment (ECT), Suicide Attempt or Ideation with a plan, Legal/Law intervention, 302 and/or Loss of Housing? **None of the above** ☐

List admission and discharge dates in past 2 years for psychiatric facilities (If any):

_____

_____

_____

☐ I attest that all information is truthful and understand that any misrepresentation or omission of information on this application will disqualify me from admission to the facility indicated and will be cause for discharge if discovered after my admission.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Person Completing Form (if not applicant) Date

_____ _____

Name of Person Completing Form (if not applicant) Relationship