THE ARBORS
AT ST. BARNABAS
85 Charity Place • Valenica, PA 16059
5827 Meridian Road • Gibsonia, PA 15044
6005 Valencia Road • Gibsonia, PA 15044
724-687-9240

BEAVER MEADOWS
AT ST. BARNABAS, INC.
5130 Tuscarawas Rd.
Beaver, PA 15009
724-495-1600

LIVING ASSISTANCE ADMISSION APPLICATION

Date Received_____ Date Admitted _____

Resident Name_____ Soc. Sec. No._____ Birthdate _____
(mo) (day) (year)

Sex: M_____ F_____ Single_____ Married_____ Widowed_____ Divorced _____

2nd Resident Name_____ Soc. Sec. No._____ Birthdate _____
(mo) (day) (year)

Address_____ City_____ ST_____ ZIP _____

Length of Time at Current Address_____ Currently live alone_____ With_____

Phone_____ Birthplace _____

Medicare No._____ Medicaid No. _____

Secondary Insurance Plan Name_____I.D.# _____

Prescription Drug Plan Name_____I.D.# _____

Former Occupation_____ Military: Enlisted_____ Discharge_____

Last Employer_____ Branch _____ Claim No. _____

Termination Date_____ Eligible for Veterans Benefits _____

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?_____ 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 _____

Long Term Care Insurance (Company)_____ Policy Covers Personal Care _____

FINANCIAL STATEMENT

ASSETS & ANNUAL INCOME

Value as of_____
(date)

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

DEBTS

Owed As Of_____
(date)

OWED TO:		Amount Owed	SECURITY (If Any)
Bank	_____ Name of Bank	$_____	_____
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

FINANCIAL STATEMENT

INCOME

			ANNUAL INCOME:
Social Security:			
First Person	Monthly SS	$_____	$_____
Second Person		$_____	$_____
Pension (First Person)			
Fixed As to Amount	_____ Source of Pension		$_____
Increases with COLA	_____ Source of Pension		$_____
Pension (Second Person)			
Fixed As to Amount	_____ Source of Pension		$_____
Increases with COLA	_____ Source of Pension		$_____
Other Recurring Income	_____ Source of Other Income		$_____
Other Recurring 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 $_____

Has the resident made any gifts in an amount greater than $500 in the past 5 years? _____

If so, what was the amount? $ _____ When was the gift made: _____

Reason for the gift:_____

Has the resident closed, sold or given away any asset(s) within the past 5 years? _____

If so, please explain the nature of the timing of the transaction: _____

_____

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

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

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a false statement may disqualify me for any future financial assistance for which I apply.

_____ _____

Signature of Applicant/Date Signature of Power of Attorney/Date