

Independent Living Application for Admission

Please answer all questions as completely and accurately as possible. Your answers will help us to provide for all phases of your living and care at Asbury Heights. Don't hesitate to contact us if you have any questions about this application. All information will be held in the strictest of confidence.

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Marital Status Single Divorced Separated Married Widowed

Date of Birth _____

Birthplace _____

700 Bower Hill Road
Mt. Lebanon, PA 15243-2040
www.asburyheights.org
phone: 412.571.5138
fax: 412-571-5108



Health Insurance Coverage

Please provide a copy of all insurance cards.

Medicare Number _____

Medicare Hospital Effective Date _____
Date issued on Medicare card

Medicaid Number _____

Social Security Number _____

Other Medical Insurance Coverage _____

ID Number _____ Group Number _____

Do you have prescription coverage? yes no

Prescription Plan Name _____

Claim Number _____
Please provide a copy of your long-term care policy

Long-term Health Care Insurance Name _____
(Please provide a copy of your policy, documentation of the cost of the monthly or annual premium, and verification that the policy is currently in effect.)

Name of Primary Care Physician _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Contact Information

Do you have a Medical Power of Attorney? yes no

Name _____ Phone _____

Do you have a Financial Power of Attorney? yes no

Name _____ Phone _____

Do you have a Living will? yes no

*Please provide a copy of your Living Will and/
or Power(s) of Attorney prior to admission.*

Where would you like your monthly Asbury bills/statements sent? self other

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Please provide your funeral home of preference.

Name _____

Address _____

City _____

State _____ Zip Code _____

Phone _____

PRIMARY CONTACT PERSON

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email Address _____

SECONDARY CONTACT PERSON

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email Address _____

TERTIARY CONTACT PERSON

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email Address _____

Personal Finances

(Listed assets must be available for your care, if needed.)

ASSETS	ESTIMATED VALUE	SOLE	JOINT
Real Estate			
Type _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Location _____			
Type _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Location _____			
Checking Account(s)			
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Savings Account(s)			
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Bank name _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Certificate(s) of Deposit			
Source _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Source _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Stocks, Bonds, and Mutual Funds			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Description _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Number of shares/bonds _____			
Trust Fund			
Bank _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Trust officer name and phone _____			
Date established (month/day/year) _____		YES	NO
Is this trust irrevocable?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have life insurance?		<input type="checkbox"/>	<input type="checkbox"/>
Estimated cash value _____	\$ _____		

LIABILITIES	AMOUNT	SOLE	JOINT
Lender _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Lender _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Lender _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

INCOME **PER MONTH**

Social Security _____ \$ _____

Wage earner, if not self _____

Pension _____ \$ _____

Type _____

Through whom, if not self _____

Veterans Administration Compensation _____ \$ _____	YES	NO
Claim Number _____	<input type="checkbox"/>	<input type="checkbox"/>

Other Income _____ \$ _____

_____ \$ _____

_____ \$ _____

I authorize Asbury Heights to verify this information with the financial institutions listed, or any other appropriate agency.

The undersigned applied for admission to Asbury Heights with the understanding that the information contained in this application is true and correct and that the incorrect information entitles Asbury Heights, at its option, to cancel any Agreements entered into with the Applicant and/or Responsible Party.

Signature of applicant or responsible party Date

Name, address, and phone number of person completing application, if not applicant.

Asbury Heights, an Oakdale Seniors Alliance Supported Community, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Asbury Heights is the marketing name used to refer to the following companies: Asbury Foundation, Asbury Villas, Asbury Place, Wesley Hills, and The Embassy of Asbury Heights.