Asbury HEIGHTS
An Oakdale Seniors Alliance Supported Community

Personal Care 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

Church/religious affiliations _____

Past occupation(s) _____

_____

Date of Birth _____

Birthplace _____

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

EQUAL HOUSING OPPORTUNITY

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

Pharmacy of choice

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.

Are you a veteran? ☐ yes ☐ no Which branch of service?

Are you the spouse of a veteran? ☐ yes ☐ no Which branch of service?

Do you have any allergies? ☐ yes ☐ no

If so, please list.

Personal Health

What is the name and phone number of your Primary Care Physician?

Name Phone

Have you been seen by your Primary Care Physician within the last year? ☐ yes ☐ no

Do you wear a hearing aid? ☐ yes ☐ no

Do you wear glasses? ☐ yes ☐ no

Do you wear dentures? ☐ yes ☐ no

Do you need a special diet? ☐ yes ☐ no

(please specify) _____

Mental Status: ☐ alert ☐ confused ☐ noisy ☐ converses with others

☐ socializes with others ☐ wanders ☐ forgetful ☐ combative

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 _____

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 _____

THIRD 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	$	☐	☐
Location			
Type	$	☐	☐
Location			
Checking Account(s)			
Bank name	$	☐	☐
Bank name	$	☐	☐
Savings Account(s)			
Bank name	$	☐	☐
Bank name	$	☐	☐
Certificate(s) of Deposit			
Source	$	☐	☐
Source	$	☐	☐
Stocks, Bonds, and Mutual Funds			
Description	$	☐	☐
Number of shares/bonds			
Description	$	☐	☐
Number of shares/bonds			
Description	$	☐	☐
Number of shares/bonds			
Trust Fund			
Bank	$	☐	☐
Trust officer name and phone			
Date established (month/day/year)		YES	NO
Is this trust irrevocable?		☐	☐
Do you have life insurance?		☐	☐
Estimated cash value	$		

LIABILITIES	AMOUNT	SOLE	JOINT
Lender	$	☐	☐
Lender	$	☐	☐
Lender	$	☐	☐

INCOME

PER MONTH

Social Security $

Wage earner, if not self

Pension $

Type

Through whom, if not self

Veterans Administration Compensation $

Claim Number

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.