Inquiry Date_____

The Williamsport Home

Resident Admission Form
CCRC (Continuing Care Retirement Community)
Independent, Assistance in Living, Apartments or Assistance in Living Suites

Primary Applicant:

Full Name _____ Sex Male Female
Last First Middle

Current Address_____ City _____

County_____ Phone (____) _____

How Long (at previous address)? _____Veteran _____ Yes _____No

If yes, what branch _____

Date of Birth_____ Birthplace: _____

Social Security Number #_____ Age_____

Drivers License #_____Insurance Cards _____

Medicare _____ Primary Physician _____

Marital Status: _____Married _____Single _____Widowed _____Divorced

Co Applicant Information:

Name_____ Medicare_____
Last First Middle

Date of Birth_____ Insurance_____

Social Security #_____ Insurance_____

Primary Physician_____ Drivers License # _____

How did you hear about The Williamsport Home? _____

Referred By_____

	Financial Information	Self	Joint
Assets	Fair Market Value of Real Estate Owned		
	Balance of Checking Accounts		
	Balance in All Savings Accounts/Money Market Assets		
	Balance of Cash if in Excess of $500.00		
	Cash Surrender Value of All Life Insurance Policies		
	Value of All Corporate Stocks or Securities		
	Value of All Trusts Whose Principle is Available for Support, Care, and Maintenance		
	Value of All Motor Vehicles – Make, Model, License #		
	Value of Other Assets in Excess of $500.00 Per Asset (Include indebtedness owed to you by others)		
	Total $		

From:

Monthly Income	Interest		
	Pensions		
	Annuities		
	All Certificates of Deposit		
	Trusts		
	Social Security Benefits (Please note individual amount below) Self $ Spouse $		
	Dividends		
	All Other Sources (rental property, part-time employment, etc)		
	Total $		
Burial Fund	Value of Prepaid Funeral Expenses Prepaid with whom		
	Total $		
Indebtedness	All Money Owed By You (please list each one separately)	Amount	

Have you transferred any assets for less than full value within the last 5 years? ☐ Yes ☐ No

Have you assigned you Medicare rights to a managed care health insurance provider? ☐ Yes ☐ No
If yes, list name of provider _____

First and Second Person Contact

Name Address Telephone

Do you currently handle your own financial affairs _____Yes _____ No

If not, who assist you in with financial payment of bills _____

Address: _____ Phone: _____

Do you have a Power of Attorney _____Yes _____No

Name _____ Phone _____

Living Will _____Yes _____No Location _____

Children

Name Address Telephone

Close Relatives and/or Friends

Name Address Telephone

Religion_____

Clergy_____ Church _____

Address_____ Address _____

_____ _____

Phone (____)_____ Phone (____)_____

Funeral Director Name_____ Phone (____)_____

Address_____

Hospital Preferred_____

Primary Physician _____

Dentist _____

Eye Doctor _____

Foot Doctor

THE WILLIAMSPORT HOME

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Full Name of Resident (Please Print): _____ ID#_____

Date of Birth _____ Adm Date_____

I, _____, hereby authorize the use or disclosure of my individually identifiable health information as described below.

1. Name(s) of organization(s), person(s), or class of persons authorized to use or disclose the information:_____

Address of Recipient_____

2. Name(s) of organization(s), person(s) or class of persons who may receive and use the information:_____

3. Description of the health information that may be used or disclosed (Please indicate the types of records that may be released - i.e., clinical summaries, laboratory reports, nurses notes, or all medical records):

_____

_____

_____

_____

Time Frame of records requested: From _____ To _____

4. The information will be used or disclosed for the following purposes (if other than treatment, payment and operations)

_____

_____

_____

5. I understand that this Authorization is optional and that I may refuse to sign this Authorization. My refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits unless allowed by law. The person/organization authorized to use and/or disclose the information will receive compensation for doing so: Yes ___ No _____I understand that I may inspect or copy the information being used or disclosed. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that action has been taken in reliance on this Authorization. This Authorization expires on _____.

_____ _____ _____

Signature of resident or resident's representative Date Time

_____

Printed name of resident or resident's representative

_____

Relationship to resident

Date signed consent received:_____ Time_____ Rec'd By_____

Records Released By_____ Title_____ Date_____ Time_____

Original-Resident's File_____ Copy-HIPAA Privacy Officer_____ Copy-Person Receiving Info_____

Resident Lifestyle Information

Name _____

Place of Birth: City _____ State _____

Military Service:_____Branch_____

Spouse: _____ deceased_____ How Long Ago _____

What did he/she do for a living _____

What activities does he/she enjoy_____

Does he/she like animals _____

Shower _____ Tub _____ Time of Day _____

Dementia? Yes _____ No_____

If yes, what symptoms exhibited prior to admission: _____

_____

_____

Daily Routines

Time up in AM _____

Time of Breakfast _____

What foods are typically eaten at breakfast _____

_____

Morning Activities _____

Time of Lunch _____

What foods are typically eaten at lunch? _____

_____

Afternoon Activities _____

Any naps during day _____ Time_____

Time of evening meal: _____

What food are typically eaten at supper_____

_____

Evening Activities _____

Miscellaneous information that will be helpful to us: _____

_____

_____

_____