Jewish Home of Eastern PA
1101 Vine Street
Scranton, PA 18510
Telephone (570) 344-6177
Fax (570) 344-9610

For Home Use Only

Application #_____ Case #_____
Application Fee Paid_____
Date Application Received_____
Interviewer_____

Application For Admission

Last Name	First Name	Middle Initial	Maiden Name

Present Address	Since
street city state zip	

Telephone Number	Social Security Number	Living Arrangements (check one)
		Own Home____ Apartment____ Other____
Date of Birth	**Age**	**Birthplace**
Religion	**House of Worship**	**Address**

Father's Name	Mother's Maiden Name

Status: (please circle):
single **married** **widowed** **divorced** **separated**

Marriages:

date	city	name of spouse	date and reason terminated

U.S. Citizen?	Veteran?	How long has applicant lived in the United States?
yes____ no___	yes____ no___	

Past Occupation	When Last Employed

Emergency Contact: Three individuals will be indicated on the Medical Record for contact purposes.

	Name	Relationship	Complete Address	Telephone
1				home cell business
responsible person / power of attorney				
2				home cell business
3				home cell business

Hospital / Rehabilitation / Nursing Home Admission Information:

Please indicate any admission within the past 12 months with specific dates for the purpose of determining Medicare coverage. Please try to give exact admission & discharge dates within the last 60 days.

	Name of Institution	City	Admission Date	Discharge Date
1				
2				
3				
4				
5				

Physician:
Address:

Phone:

Podiatrist:
Address:

Phone:

Dentist:
Address:

Phone:

Eye Doctor:
Address:

Phone:

Funeral Director:
Address:

Phone:

Cemetery:
Address:

Referral Source:

Financial Information: *

An appointment must be scheduled with the Business Office Manager for further financial details prior to or on the day of admission. Please call 570-344-6177 ext 103 to arrange an appointment.

Applicant Financial Resource Assessment Questionnaire

(for purposes of applying for Medical Assistance)

	Yes/No
1 Has the applicant sold, given away, gifted or transferred assests in the past 5 years? (cash, property, real estate)	_____
2 Does the applicant own annuities, mutual funds, stocks or bonds?	_____
3 Does the applicant have life insurance policies?	_____
4 Does the applicant have a pre-paid burial arrangement?	_____
5 Does the applicant have an annuity, life estate or trust?	_____

At the current rate of $300 per day for a semi-private room,

the monthly charge for a thirty day month totals $9,000.00.

Based on the Jewish Home's private pay rate, the applicant has liquid assets to cover _____ months/years,

before applying for Medical Assistance.

Guarantor for resident: Address: Phone:

e-mail:

Responsible Person: Address: Phone:

e-mail:

Signature of Applicant: Signature of Responsible Person:

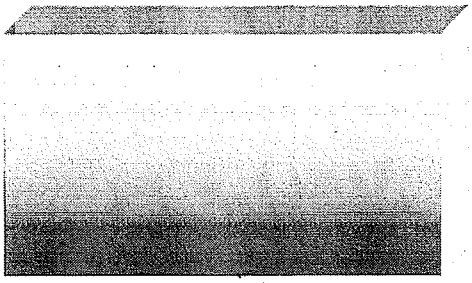
***Application cannot be processd unless all areas are completed.**

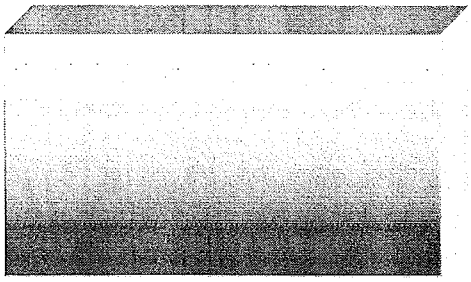
Health Insurance Information

Type	Company Name	Number	Effective Date
Medicare			
Co-Insurance			
Medicare "D" Plan			
HMO			
Medical Assistance			
Other			

Address: Phone:

Please attach copies of all insurance cards below or on a separate sheet:





If unable to obtain copies, present original to the Business Office and copies will be made.

If unable to locate cards, please provide a copy of most recent insurance statement to verify numbers.