

JEWISH HOME of Eastern Pennsylvania

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:			
<u>date</u>	<u>city</u>	<u>name of spouse</u>	<u>date and reason terminated</u>
_____	_____	_____	_____
_____	_____	_____	_____
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
	resident representative / power of attorney			
2				home cell business
3				home cell business

Jewish Home of Eastern PA

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:

Jewish Home of Eastern PA

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 1103 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 assets 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 \$330 per day for a semi-private room, \$345 per day for a private room.

the monthly charge for a thirty-one day month totals \$10,230.00

**Based on the Jewish Home's private pay rate, the applicant has liquid assets to cover _____ months/years,
before applying for Medical Assistance.**

Resident Representative:	Address:	Phone:
		e-mail:

Signature of Applicant: _____

Signature of Resident Representative: _____

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

Jewish Home of Eastern PA

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.