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	
resident representative / power of attorney				email	
2				home	
				cell	
				business	
				email	
3				home	
				cell	
				business	
				email	

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 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 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 $350 per day for a semi-private room, $365 per day for a private room.

the monthly charge for a thirty-one day month totals $10,540.00

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.**

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.