OUR HOME OF HOPE INC.
A PERSONAL CARE FACILITY
223-225 Cherry Street
Columbia, PA 17512-1409
Phone: (717) 684-7060 Fax: (717) 684-7059

Applicants Information:

Full Name _____ Phone (____) _____

Current Address:

Street_____

City _____ State _____ Zip Code _____

Social Security No. _____ Gender ☐Male ☐Female ☐Other_____

Date of Birth _____ Place of Birth _____

Primary Language _____ Religious Affiliation _____

Marital Status:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐Other _____

Spouses Information (if applicable):

Spouses Name _____

Spouses Address _____

_____

If Deceased Date of Death _____ Where Buried _____

List of Children (if applicable)

Name	Address	Phone

Medical Administrative Information:

Medicare No. _____ Medicaid No. _____

Health Insurance Co. _____ Policy No. _____

Phone No. _____ Address _____

Additional Prescription Plan ☐Yes ☐No (if yes please list plans below)

Plan Name: Plan Number: Expiration Date:

_____

_____

Personal Physician _____ Phone _____

Physician Address _____ Zip Code _____

Dentist _____ Phone _____

Dentist Address _____ Zip Code _____

Specialist _____ Phone _____

Specialist Address _____ Zip Code _____

Personal Health Information:

Height _____ Weight _____ Hair Color _____ Eye Color _____

Identifying Marks _____

Glasses? ☐Yes ☐No Dentures? ☐Yes ☐No Hearing Device? ☐ Yes ☐ No

Current Health Status: ☐Excellent ☐ Good ☐ Fair ☐ Poor ☐ Actively Dying

Hearing: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Eyesight: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Ambulation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Speech: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently using a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Leg Braces ☐ Other _____

Has an MA-51 been completed? □ Yes □ No If so, Date Completed _____

Has a DME been completed? □ Yes □ No If so, Date Completed _____

*** Please note that it is a requirement for admission to have each of these forms completed. ***

Additional Medical Equipment Used:

_____

_____

List your last hospitalizations in the last year

Hospital Date Reason

_____

_____

_____

Allergies:

Medication: □ Yes □ No If yes, _____

Food: □Yes □ No If yes, _____

Others: □ Yes □ No If yes, _____

Diet:

□ None □ Cardiac □ Diabetic □ Soft □ Pureed Food □ Other _____

Immunizations:

Flu Vaccine: □ Yes □ No Date Received _____

Pneumonia Vaccine: □ Yes □ No Date Received _____

Td/Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: □ Yes □ No Date Received _____

Shingles Vaccine: □ Yes □ No Date Received _____

Current Diagnosis:

_____

_____

_____

Please Check any of the following you have had in the past:

□Heart Disease	□High Blood Pressure	□Incontinence	□Cancer
□Diabetes	□Low Blood Pressure	□Memory Loss	□Tuberculosis
□Stroke	□Arthritis	□Confusion	□Cataracts
□Paralysis	□Limb Impairments	□Parkinson's Disease	

Please Check any of the following you need assistance with:

□Ambulating	□Dressing	□Finances	□Special Diet
□Eating	□Bathing	□Transportation	□Toilet
□Medications	□Laundry	□Housekeeping	□Grooming
□Telephone Use	□Interpreter Service	□Sign Language	

Personal Information:

Nickname _____

Where have you lived most of your life? _____

With whom do you live with now? _____

Your profession, trade or occupation? _____

Highest grade level attained in school? _____

List your Hobbies or Interests _____

Any special dates we should be aware of? _____

Do you use Tobacco? □Yes □No If so, How much? _____

Do you drink Alcohol? □ Yes □No If so, How much? _____

Do you use Narcotics? □Yes □No If so, How much? _____

Have you applied to any other facilities? □ Yes □ No

Have you ever lived in another facility? □ Yes □ No If so, Where _____

Are you or your spouse a veteran? □ Yes □ No If so, What branch? _____

If so, did you serve during war time? □ Yes □ No If so, Which campaign? _____

Do you have a Power of Attorney? □ Yes □ No If so, complete information below

Name _____ Relationship _____

Address _____ Zip Code _____

Home Phone _____ Cell Phone _____

What type of Power of Attorney (POA) is held?

□Non-Durable POA □Durable POA □Special/Limited POA □Medical POA □Springing POA

Do you have a Funeral Home that should be notified at time of death?

Name _____ Phone _____

Address _____Zip Code _____

Name and Location of Cemetery _____

Do you have a Last Will & Testament? □ Yes □ No If so, who has the document?

Name _____ Phone _____

Address _____ Zip Code _____

Do you have a Living Will? □ Yes □ No If so, who has the document (copy must be kept at facility)?

Name _____ Phone _____

Address _____ Zip Code _____

Emergency Information:

Person to be contacted in case of emergency:

- Name _____ Relationship_____ Phone _____

  Address _____ Zip Code _____
- Name _____ Relationship _____ Phone _____

  Address _____ Zip Code _____

Financial Information:

Financial Statement:

Please indicate if this is a joint financial statement of a couple or of an individual _____

	Assets		Liabilities
Cash and Checking	$_____	Notes payable	$ _____
Saving/Money Maker Acct.	$ _____	Mortgage Payable	$_____
Certificates of Deposits	$ _____	Other Debts	$ _____
Stocks and Bonds	$ _____	_____	
Real Estate Owned	$ _____	_____	
Trust Account	$ _____	_____	
Other Assets	$ _____	_____	
Total Assets Available	$ _____	Total Liabilities	$_____

Source of Income (Monthly-Net)

Social Security	$ _____
Pensions and Annuities	$ _____
Dividends and Interest	$ _____
Other Income	$ _____
Total Monthly Income	$ _____

Miscellaneous Financial Data:

Life Insurance? □ Yes □ No If so, Value? _____

Automobile(s) □ Yes □ No If so, Make & Model? _____

VIN No. (If being kept on Property)? _____

Auto Insurance Co. _____ Phone _____

Policy No. _____ Effective Date _____ NAIC _____

Other _____

I hereby certify that the above information is correct and complete to the best of my knowledge. I understand that any misrepresentation could result in the forfeiture of my application or status as a resident of Our Home of Hope. I understand that this application does not obligate Our Home of Hope in any way and is submitted to be placed on file and that the above information is strictly confidential.

Signed _____Date _____
Applicant or Power of Attorney