



**THE ARBORS  
AT ST. BARNABAS**

85 CHARITY PLACE • VALENICA, PA 16059  
5827 MERIDIAN ROAD • GIBSONIA, PA 15044  
724-625-4000, EXT. 258

**ADMISSION FORM**

Date Received \_\_\_\_\_

Date Admitted \_\_\_\_\_

Resident Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Length of Time at Current Address \_\_\_\_\_ Currently live alone \_\_\_\_\_ With \_\_\_\_\_

Birthplace \_\_\_\_\_ Birthdate \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
(mo) (day) (year)

Soc. Sec. No. \_\_\_\_\_ Medicare No. \_\_\_\_\_ Medicaid No. \_\_\_\_\_

Secondary Insurance Plan Name \_\_\_\_\_ I.D.# \_\_\_\_\_

Prescription Drug Plan Name \_\_\_\_\_ I.D.# \_\_\_\_\_

Former Occupation \_\_\_\_\_ Military: Enlisted \_\_\_\_\_ Discharge \_\_\_\_\_

Last Employer \_\_\_\_\_ Branch \_\_\_\_\_ Claim No. \_\_\_\_\_

Termination Date \_\_\_\_\_ Eligible for Veterans Benefits \_\_\_\_\_

Primary Contact:

\_\_\_\_\_  
Name (Last) (First) Telephone No. Relationship

\_\_\_\_\_  
Address City State ZIP

Secondary Contact:

\_\_\_\_\_  
Name (Last) (First) Telephone No. Relationship

\_\_\_\_\_  
Address City State ZIP

Tertiary Contact:

\_\_\_\_\_  
Name (Last) (First) Telephone No. Relationship

\_\_\_\_\_  
Address City State ZIP

**GENERAL INFORMATION**

Have you resided in any other Home or Institution? \_\_\_\_\_ Dates \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Nature and onset of illness \_\_\_\_\_ Date \_\_\_\_\_

Mental Status \_\_\_\_\_ Bedfast \_\_\_\_\_ Confined to wheelchair \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Drink? \_\_\_\_\_

Who will take care of burial arrangement? \_\_\_\_\_

Who will pay funeral expenses? \_\_\_\_\_

Funeral Director to be notified \_\_\_\_\_ Phone \_\_\_\_\_

Has a will been made? \_\_\_\_\_ Where can it be located? \_\_\_\_\_

Who is responsible for your personal belongings? Name \_\_\_\_\_

Address \_\_\_\_\_

Is life insured? \_\_\_\_\_ Who pays premium? \_\_\_\_\_

Insurance Company \_\_\_\_\_ Beneficiary \_\_\_\_\_

Give name, address, and phone number of Executor and Attorney \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name P.O.A. Financial/Relationship \_\_\_\_\_

Name P.O.A. Healthcare/Relationship \_\_\_\_\_

**FINANCIAL STATEMENT**

**ASSETS & ANNUAL INCOME**

Value as of \_\_\_\_\_

(date)

	\$ Value of Asset	Annual Income from Asset
Real Estate		
Residence _____	\$ _____	\$ _____
Cash: Savings _____	\$ _____	\$ _____
CDs _____	\$ _____	\$ _____
Money Market Accts. _____	\$ _____	\$ _____
Marketable Securities:		
Stocks _____	\$ _____	\$ _____
Bonds _____	\$ _____	\$ _____
Mut. Funds _____	\$ _____	\$ _____
Proceeds from Life Ins. _____	\$ _____	\$ _____
(Complete page 4)		
Cash Surrender Value of Ins. _____	\$ _____	\$ _____
Trust and Custodial Accounts _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____

Identify Source(s)

TOTALS           \$ \_\_\_\_\_           \$ \_\_\_\_\_

**DEBTS**

Owed As Of \_\_\_\_\_

(date)

**Amount Owed**

**SECURITY (If Any)**

OWED TO:

Bank \_\_\_\_\_ \$ \_\_\_\_\_

Name of Bank

Mortgage \_\_\_\_\_ \$ \_\_\_\_\_

Name of Lender

Credit Card VISA \_\_\_\_\_ \$ \_\_\_\_\_

Credit Card MASTERCARD \_\_\_\_\_ \$ \_\_\_\_\_

Credit Card DISCOVER \_\_\_\_\_ \$ \_\_\_\_\_

Credit Card AMERICAN EXPRESS \_\_\_\_\_ \$ \_\_\_\_\_

Credit Card \_\_\_\_\_ \$ \_\_\_\_\_

Finance Company \_\_\_\_\_ \$ \_\_\_\_\_

Name of Lender

Other \_\_\_\_\_ \$ \_\_\_\_\_

Name of Lender

**FINANCIAL REFERENCES**

Bank \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

Bank \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

Trust Co. \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

Other \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

**FINANCIAL STATEMENT**

**INCOME**

**ANNUAL INCOME:**

Social Security:

First Person Monthly SS \$ \_\_\_\_\_

Second Person \$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Pension (First Person)

Fixed As to Amount \_\_\_\_\_ \$ \_\_\_\_\_

Source of Pension

Increases with COLA \_\_\_\_\_ \$ \_\_\_\_\_

Source of Pension

Pension (Second Person)

Fixed As to Amount \_\_\_\_\_ \$ \_\_\_\_\_

Source of Pension

Increases with COLA \_\_\_\_\_ \$ \_\_\_\_\_

Source of Pension

Other Recurring Income \_\_\_\_\_ \$ \_\_\_\_\_

Source of Other Income

Other Recurring Income \_\_\_\_\_ \$ \_\_\_\_\_

Source of Other Income

**TOTAL ANNUAL INCOME** \$ \_\_\_\_\_

**ROUTINE EXPENSES**

• Average Cost of Monthly Medications \$ \_\_\_\_\_

Does Applicant have an active PACE Card? YES NO  
(Circle One)

• Apartment for Housing Rent \$ \_\_\_\_\_  
Rent Obligation Ends \_\_\_\_\_  
(Date)

• Monthly Supplemental Insurance Payments \$ \_\_\_\_\_  
(Medicare Part B, Blue Cross/Blue Shield, etc.)\*

• Life Insurance Payment\* \$ \_\_\_\_\_

• Long Term Care Policy Payment\* \$ \_\_\_\_\_

Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_

\* If payment is quarterly, divide quarterly payment by 3 to determine monthly amount.

TOTAL MONTHLY ROUTINE EXPENSES \$ \_\_\_\_\_

Do you give St. Barnabas Health System permission YES NO  
to run a credit report? (Circle One)

These are my assets, debts, liabilities and sources of income as of \_\_\_\_\_  
(Date)

\_\_\_\_\_  
Signature of Applicant/Date

\_\_\_\_\_  
Signature of Power of Attorney/Date