

## PRE-ADMISSION CHECKLIST

1. APPLICATION FOR ADMISSION
2. MEDICAL EVALUATION FORM WITH MANTOUX TEST RESULTS FROM DOCTOR
3. LIVING WILL (we will make copies)
4. POWER OF ATTORNEY (we will make copies)
5. MEDICARE CARD
6. PACE CARD
7. HEALTH CARDS  
(Blue Cross – Blue Shield, Security Blue, UMWA. Railroad, Steelworkers, any other medical cards you may have.)
8. PHARMACY  
(May continue with existing Pharmacy if they deliver to The Atrium...a Choice Community or may use from in-house Martella's Pharmacy- which delivers daily to our facility.)
9. CLOTHING  
(The resident should be accompanied with approximately seven changes of clothing, shoes, socks and slippers should also be available for the resident's use. All items must be clearly marked with the resident's room number.)

# TheAtrium . . . A Choice Community

216 Main Street  
Johnstown, PA 15901  
Phone (814) 535-5347  
FAX (814) 539-4460

## APPLICATION FOR ADMISSION

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Medicare No. \_\_\_\_\_  
Blue Cross/Blue Shield No. \_\_\_\_\_ Other Hospital Insurance \_\_\_\_\_  
Religion \_\_\_\_\_ Minister/Rabbi/Priest \_\_\_\_\_  
Church \_\_\_\_\_ Address \_\_\_\_\_  
Hospital \_\_\_\_\_ Phone No. \_\_\_\_\_  
Funeral Home \_\_\_\_\_  
Phone No. \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widow \_\_\_\_\_ Widower \_\_\_\_\_ Other \_\_\_\_\_

Spouse:

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

Persons to be notified in case of emergency:

Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
Phone No. _____	Phone No. _____

FINANCIAL INFORMATION:

Bank Accounts:

Checking – Amount \$ \_\_\_\_\_

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

Savings – Amount \$ \_\_\_\_\_

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

Real Estate:

Residence -- Value \$ \_\_\_\_\_

Other -- Value \$ \_\_\_\_\_

Address \_\_\_\_\_

Other Income:

Pension – Amount \$ \_\_\_\_\_

Social Security -- Amount \$ \_\_\_\_\_

Other-- Amount \$ \_\_\_\_\_



Additional contributions towards the cost of facility stay \$ \_\_\_\_\_

By Whom: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who supervises your financial affairs?

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

Phone No. \_\_\_\_\_

Do you have a will? Yes \_\_\_\_\_ No \_\_\_\_\_

Executor \_\_\_\_\_ Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Power of Attorney? Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICAL:**

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Do you Smoke: \_\_\_\_\_ Do you Drink? \_\_\_\_\_

What are your social interest? \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_

Referred by \_\_\_\_\_

**PLEASE CHECK IF YOU REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING:**

- \_\_\_\_\_ Self administration of medications
- \_\_\_\_\_ Remembering medications schedule
- \_\_\_\_\_ Ordering Medications
- \_\_\_\_\_ Keeping Appointments
- \_\_\_\_\_ Dressing
- \_\_\_\_\_ Bathing
- \_\_\_\_\_ Eating
- \_\_\_\_\_ Shopping
- \_\_\_\_\_ Personal Grooming
- \_\_\_\_\_ Other \_\_\_\_\_

To the best of my knowledge the foregoing statements and facts made  
By me and the herein contained, and are true and correct.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

**ADULT RESIDENTIAL LICENSING – PERSONAL CARE HOMES  
RESIDENT MEDICAL EVALUATION - 55 Pa.Code § 2600.141**

*(To be completed within 60 days prior to admission or within 30 days after admission)*

*Required for ALL residents. For residents who receive SSI a MA-51 medical evaluation form is also required.*

<input type="checkbox"/> NEW	1. NAME OF APPLICANT	2. SOCIAL SECURITY NUMBER	3. BIRTHDATE	4. AGE	5. SEX
<input type="checkbox"/> UPDATED					
6. PHYSICIAN SIGNATURE (Printed)		7. PHYSICIAN SIGNATURE		8. DATE	9. PHYSICIAN LICENSE NUMBER
10. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	
11. MEDICAL HISTORY: (Attach a signed and dated separate sheet if additional documentation is necessary)					
12. DIAGNOSES:					
13. COMMUNICABLE DISEASE: Is the individual free of Communicable Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
14. IMMUNIZATIONS: Are immunizations up-to-date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Tetanus / Diphtheria / Acellular Pertussis (Td/Tdap) (every 10 years) Date: _____					
Influenza (every year) Date: _____ Other – List Immunization & Date: _____					
15. ALLERGIES - List known allergies: (Attach a signed and dated separate sheet if additional documentation is necessary) <input type="checkbox"/> NONE <input type="checkbox"/> UNKNOWN					
16. EMERGENCY EVACUATION - Mobility Needs: In the event of an emergency, how much assistance does the applicant require to vacate the building? (Check All Applicable)			18. RECOMMENDATION FOR APPROPRIATE LEVEL OF CARE:		
<input type="checkbox"/> Unable to move from one location to another without physical assistance from others <input type="checkbox"/> Unable to move from one location to another without oral prompting from others <input type="checkbox"/> Difficulty understanding and following oral directions in the event of an emergency <input type="checkbox"/> Independently mobile with ambulation device. Specify device used: _____ <input type="checkbox"/> Walks without assistance					
17. MEDICATION ADMINISTRATION – Self-Administer Medications: Is the applicant capable of administering his/her own medications? (Check All Applicable)					
<input type="checkbox"/> Can self-administer medications with no assistance from others <input type="checkbox"/> Can self-administer medications with assistance to store medications in a secure place <input type="checkbox"/> Can self-administer medications with assistance in remembering schedule <input type="checkbox"/> Can self-administer medications with assistance in offering medications at prescribed times <input type="checkbox"/> Can self-administer medications with assistance in opening container or locked storage area OR (Check) <input type="checkbox"/> Cannot self-administer medications					
19. PHYSICIAN ORDERS (Record as "NONE" if there are no special needs related to the following):					
Medications <input type="checkbox"/> NONE _____					
_____					
Treatment/Therapies <input type="checkbox"/> NONE _____					
_____					
Diet <input type="checkbox"/> NO SPECIAL DIET _____					
Activities/Social Services _____					
Body Positioning <input type="checkbox"/> N/A _____					