



1030 STATE STREET  
BADEN PA, 15005  
724-869-6300

*No person shall, on the grounds of race, religion, color, national origin, ancestry, age, disability or sex be excluded from admission consideration or otherwise be subject to discrimination in the provision of any care or service.*

### PERSONAL INFORMATION

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

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Occupation Most of Life \_\_\_\_\_ Last Employer \_\_\_\_\_

Resided Most of Life \_\_\_\_\_ Education (Last Grade Completed ) \_\_\_\_\_

Military Service \_\_\_\_\_ Date of Service \_\_\_\_\_

Church \_\_\_\_\_ Pastor's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

#### MARITAL STATUS:

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Date of Spouse's Death \_\_\_\_\_

#### PRIMARY CONTACT PERSON/RESPONSIBLE PARTY

Name \_\_\_\_\_ Phone No. Home \_\_\_\_\_

Address \_\_\_\_\_ Phone No. Work \_\_\_\_\_

Relationship \_\_\_\_\_

#### SECONDARY CONTACT PERSON (Must reside at different address than primary contact person)

Name \_\_\_\_\_ Phone No. Home \_\_\_\_\_

Address \_\_\_\_\_ Phone No. Work \_\_\_\_\_

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**On the day of admission, it is important that the responsible party meet with Villa Staff to sign the necessary documents, present all insurance cards including Social Security card, and if available, copies of the Advance Directive (Living Will) and Power of Attorney documents.**

**HEALTH/PHYSICIAN INFORMATION**

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Present Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

**PREVIOUS STAY IN ANOTHER NURSING HOME/PERSONAL CARE BOARDING HOME**

Name of Facility \_\_\_\_\_

Dates of Stay \_\_\_\_\_ Reason for Discharge \_\_\_\_\_

**MOST RECENT HOSPITALIZATION**

Name of Hospital \_\_\_\_\_

Dates of Stay \_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_

Ambulance Service Membership \_\_\_\_\_

**HEALTH INSURANCE**

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Social Security No. \_\_\_\_\_

Medicare No. \_\_\_\_\_ Part A Effective Date \_\_\_\_\_

Part B Effective Date \_\_\_\_\_

PA Access/Medicaid \_\_\_\_\_

Blue Cross Group No. \_\_\_\_\_ HMO Type \_\_\_\_\_

Agreement No. \_\_\_\_\_ ID No. \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

Pace Card No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

VA Medical Benefits \_\_\_\_\_

**LONG TERM HEALTH CARE**

Carrier \_\_\_\_\_

Agreement No. \_\_\_\_\_

Other Medical Insurance Coverage (AETNA, MetLife, Bankers Life, AARP, Travelers, Etc.)

\_\_\_\_\_  
\_\_\_\_\_



HOW DID YOU LEARN ABOUT THE FACILITY? Please check all that apply.

Newspaper \_\_\_\_\_ Physician \_\_\_\_\_ Magazine Ad \_\_\_\_\_ Clergy/Church \_\_\_\_\_  
Social Worker \_\_\_\_\_ Friend \_\_\_\_\_ Other (Specify) \_\_\_\_\_

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**ACKNOWLEDGEMENT**

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I understand that by making this application, I do not obligate myself to enter the Facility, if invited; nor do I hold Villa St. Joseph responsible for accepting me if for any reason it deems I cannot be received.

Furthermore, it is expressly understood and agreed that the information submitted in this application constitutes the inducement upon which I will be considered for residence, and that this application shall become a part of any subsequent agreement between the Facility and me. Neither the Facility nor I is under obligation until the application has been approved by the Facility and the Admissions Agreement executed.

I make this application and medical information for residency to the Facility of my own free will. I certify that all information herein is true and correct to the best of knowledge. I further understand that any intentional falsification about my resources can affect my final occupancy.

I have read or had read to me this application and fully understand.

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

Signature of Responsible Person Signing for Applicant (if applicant is unable to sign)  
\_\_\_\_\_  
Date \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_