Cornerstone LIVING
Memory Care Community

4605 Werley's Corner Road
New Tripoli, PA 18066
Ph: 610.298.3300

RESIDENT APPLICATION INFORMATION

*FIRST NAME*_____ *LAST NAME*_____

*BIRTHDATE*_____ *AGE*_____

*GENDER*_____

*SOCIAL SECURITY*_____*RACE/ETHNICITY*_____

*CURRENT ADDRESS*_____

*MARTIAL STATUS*_____

*RELIGIOUS AFFILIATION*_____

DESIRED DATE OF RESIDENCE: _____

TERM CHOICE: LONG/ SHORT: _____

*REFERRED BY*_____

BILLING, POWER OF ATTY, DESIGNATED PARTY AND EMERGENCY INFORMATION

DESIGNATIONS ARE: PA – POWER OF ATTY BP – BILLING PARTY
DP – DESIGNATED PARTY (Emergency Contact Party)

PERSON: _____*RELATIONSHIP:* _____

DESIGNATIONS: _____

HOME PHONE: _____ *WORK PHONE:* _____

ADDRESS: _____

PERSON: _____*RELATIONSHIP:* _____

DESIGNATIONS: _____

HOME PHONE: _____ *WORK PHONE:* _____

ADDRESS: _____

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PERSON: _____ *RELATIONSHIP:* _____

DESIGNATIONS: _____

HOME PHONE: _____ *WORK PHONE:* _____

ADDRESS: _____

INFORMATION IN THE EVENT OF DEATH

*FAMILY MEMBER – NAME*_____

*ADDRESS*_____

HOME PHONE: _____ *WORK PHONE:* _____

MORTUARY: _____

*ADDRESS*_____

*PHONE*_____

*PARISH – NAME AND CONTACT*_____

*PHONE*_____

SOURCE OF INCOME

*SOCIAL SECURITY AMOUNT*_____
PENSION AMOUNT _____
*INTEREST INCOME AMOUNT*_____
OTHER INCOME _____
TOTAL MONTHLY INCOME _____

MEDICAL ADMINISTRATIVE INFORMATION

MEDICARE NUMBER: _____

INSURANCE COMPANY: _____ *POLICY/GROUP #*_____

HOSPITAL PREFERENCE: _____

AMBULANCE SERVICE: _____

OTHER MEDICAL INFORMATION

AMBULATORY STATUS: Independent Cane Walker Wheelchair Bed bound

DIET: _____

FLU SHOT YES NO DATE RECEIVED: _____

PNEUMONIA SHOT YES NO DATE RECEIVED: _____
TETANUS SHOT YES NO DATE RECEIVED: _____
DENTURES YES NO
GLASSES YES NO
HEARING AIDS YES NO
CONTINENT OF BOWEL YES NO

ALLERGIES: _____

ALLERGY MEDICATION FOOD INSECT BITES

IF YES, DESCRIBE_____

PRIMARY PHYSICIAN: _____ OFFICE: _____

ALTERNATE PHYSICIAN: _____ OFFICE: _____

PODIATRIST: _____ OFFICE: _____

DENTIST: _____ OFFICE: _____

HOSPITAL: _____

HOSPITALIZATIONS WITHIN THE LAST YEAR/SUBSEQUENT DIAGNOSIS:

_____

OTHER OPTIONAL INFORMATION:

_____

_____

_____

DATE OF APPLICATION: _____