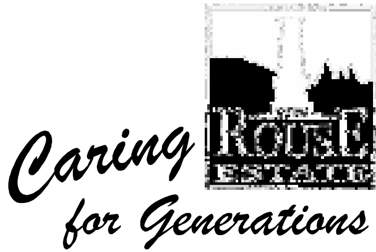

The Rouse Estate

701 Rouse Avenue, Youngsville, Pennsylvania 16371
(814) 563-7565 Fax (814) 563-9049

APPLICATION FOR ADMISSION

FOR SUITES AT ROUSE
Return to:
Suites At Rouse
615 Rouse Avenue
Youngsville, PA 16371

Fax #: (814) 563-7450
Phone: (814) 563-1650

FOR ROUSE HOME
Return to:
Admission Department
701 Rouse Avenue
Youngsville, PA 16371

Fax # (814) 563-9049
Phone: (814) 563-6500

I. BACKGROUND INFORMATION:

Name: ____ Telephone (____) ________________

Address: ____

City: ___________________________ State: _______________ Zip Code: _________________

Date of Birth: ______/______/______

Please check the appropriate item: ( ) White/non-minority, ( ) American Indian, ( ) Black
( ) Spanish American, ( ) Asian/Pacific Island,
( ) Other_______________________________________

( ) I do not wish to furnish information regarding my nationality. I understand this will not affect my admission status.

Referral Source: ____

Education: ____

Last Place Of Employment/ Occupation: ____

Religion: ___________________________Church Affiliation: _____________________________

Church Address: ____

Church Phone #: _____________________________________

Marital Status: ___________ (If Applicable) Date and place of Marriage: __________________
Spouse Surviving: ( ) Yes ( ) No
Name of Spouse: ___________________________
Spouse Birthdate: ___________________________
Date of Death: _____________________________

Please List Next Of Kin, In Oder Of Those To Be Notified First In Case Of An Emergency:

Name Address Relationship Phone number/E-Mail (Home, Work, Cell)

____

____

____

____

II. LEGAL DOCUMENTS:

Does the applicant have a Power of Attorney? ____NO ____YES (If yes, please attach a copy)
A Legal Guardian? ____NO ____YES (If yes, please attach a copy)

Name and Address of Power of Attorney/ Guardian: ___________________________________

**If applicant has no Power of Attorney or Guardian, please give a name and address of a person who will act as a guarantor, and ensure that the applicant's bill is paid on a monthly basis:

____

Does the applicant have a "Living Will"? _____NO ____YES (If yes, please attach a copy)

Have funeral arrangements been pre-paid for the applicant? ____________________________

Preferred funeral home name, address and phone number: ______________________________

____

Have arrangements been made for the donation of body of specific organs? ____NO ____YES

If yes, with whom? ____

III. MEDICAL INFORMATION:

Your Physician's Name: ________________________________

Address: ________________________________

Telephone: ________________________________

Your Dentist's Name: ________________________________

Address: ________________________________

Telephone: ________________________________

Your Eye Doctor's Name: ________________________________

Address: ________________________________

Phone: ________________________________

** If applying for Rouse Home please indicate a first and second choice physician from the following list:

Dr. Ronald Simonsen________

Dr. F. David Clifford________

Dr. Jay Endres ________

Dr. John Robertson ________

Dr. John Sutton ________

Other Physician's Name: ________________________________

Address: ________________________________

Phone: ________________________________

Hospital Preference: ____

Please list any upcoming doctor's appointments that are currently scheduled (Date/Time/ Place):

____

____

____

Please list any admissions to hospitals, rehabilitation centers, nursing homes and personal care boarding home:

____

____

____

IV. MEDICAL HISTORY AND HEALTH STATUS:

List any surgeries & dates: ____

____

Is applicant currently receiving, or since January 1st of this year have they received, any therapies?
(Physical Therapy, Occupational Therapy, and/or Speech Therapy)
_____No _____YES (IF YES, please list date /location and reason for therapy): _____________

____

List any medication allergies (If Any): ____

____

Fill in the most recent dates for the following vaccinations: Flu Shot ______________________
Pneumovax: _________ Tetanus: ________ PPD In last year: NO _______ YES _________

Prosthetic Devices: (Check all that apply) _____Cane _____Walker _____Manual Wheelchair
_____Motorized Wheelchair ______Hearing Aid(s) - Left [ ] Right [ ]
_____Denture(s) – Upper [ ] Lower [ ] Partial [ ] Own teeth [ ]
_____Eyeglasses ______Pacemaker
_____Others (Please Explain):______________________________________

Does applicant require a special diet? _____NO _____YES (IF YES, please explain) - ________

____

Does applicant require assistance getting in and out of the tub or shower? _____NO _____ YES
(IF YES, please explain) ____

(Please check all that apply):
Does the applicant: Bathe self? _____ NO _____YES
Have difficulty controlling their bowels? _____NO _____ YES
Have difficulty controlling their bladder? _____NO _____YES
Do they smoke? ______NO _____YES
Do they drink alcohol? ______Daily ______Occasionally _____Never
Do they use oxygen? _____NO _____YES (If yes) Supplier___________

____

Please describe applicants appetite (check all that apply): ______Good ______Fair _____Poor

Is the applicant currently living alone? _____Yes ______NO (If NO, who is with the applicant?)

____

V. INSURANCE COVERAGE: (PLEASE ATTACH a copy of all insurance cards)

Applicants Social Security No. ______/______/______
Applicants Medicare No.______/______/______ Hospital Effective Date: ________________
Medicare Effective Date: _______________

Other Health Insurance: ________________________ID #: _____________________________
Group #: ________________ Telephone: ________________________

Other Health Insurance: ________________________ID #: _____________________________
Group #: _________________Telephone: ________________________

PACE Membership Number: ____________________Effective Date: _____________________
Expires: __________________________

Prescription Coverage Co. Name: ________________ID #: ____________________________
Group#:_________________ Telephone:
____

Is the applicant a veteran: ______NO ______YES
(IF YES) Was he/she a war time veteran? ______NO ______YES
Is applicant's spouse a veteran: ______NO ______YES
(IF YES) Was he/she a war time veteran? ______NO ______YES

VI. FINANCES:

Please fill out the correct amount & check appropriate line:

Social Security: $__________/ Month (____Check mailed to home ___Direct deposit)
SSI: $ __________/Month (____Check mailed to home ___Direct deposit)
Pension: $ __________/Month (____Check mailed to home ___Direct deposit)
Pension from: ____
VA: $ __________/ Month (____Check mailed to home ___Direct deposit)
Salary/Wages: $__________/ Month (____Check mailed to home ___Direct deposit)
Salary from: ____
Other income: $__________/Month (____Check mailed to home ___Direct deposit)
Other income from: ____

** If applying to the Rouse Home, Section VII does not need to be disclosed if assets are over $5,000.00. However, it is the guarantor's responsibility to inform the Admissions Department at the Rouse Home when assets are at $10,000.00 so the Medial Assistance Application can be initiated.

VII. FUNDS
PLEASE COMPLETE SECTION VII IF APPLYING FOR SUITES AT ROUSE

Checking Account(s):
Bank Name: _______________________Balance: ___________________________
Bank Name: _______________________Balance: ___________________________

Savings Account(s):
Bank Name: ________________________Balance: __________________________
Bank Name: ________________________Balance: __________________________

Stocks, Bonds, Certificate of Deposit:

Name	Market Value
______________________________	____________________________________
______________________________	___________________________________
______________________________	____________________________________

Real Estate (Owned):

Location	Approximate Value
_______________________________	____________________________________
_______________________________	____________________________________
_______________________________	____________________________________

Other investments and/or Assets: ____

PLEASE COMPLETE SECTIONS VII – XI IF APPLYING FOR SUITES AT ROUSE. IF APPLYING FOR ROUSE HOME PLEASE GO TO SECTION X.

VIII. DRIVING INFORMATION:

Do you drive? ___NO ___YES (IF YES) Do you have your own vehicle? ___NO ___YES

Driver's License #: _______________________________State: _____________________

Care Make and Year: ____________________License Plate #: _____________________

IX. TYPE OF APARTMENT DESIRED:

Alcove: ______Studio: ______One Bedroom: ________Deluxe: _______

X. ADMISSION POLICY:

It is the policy of the Rouse Estate to admit and to treat all resident without regard to race, color, national origin, ancestry, age, sex, religious creed, disability or handicap. As such no resident shall be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service on the grounds of race, color, nation origin, ancestry, age, sex religious creed, disability or handicap.

I give permission for medical and financial information to be shared between the Rouse Home and the Rouse Suites to the extent necessary to assist the resident to attain appropriate care or to comply with applicable laws/ regulations.

I certify that I have read the admission policy or have had it read to me and apply for admission, answering questions to the best of my knowledge, with the understanding that these conditions will apply to me as a resident of the Rouse Estate.

XI. AFFIDAVIT:

I, ________________________________, certify that the information provided on this application is true and correct to the best of my knowledge and belief.

Signature____Date_________________________

Application received on_______/_______/_______ Initials: _____________