Saint Joseph Villa
Requirements for Admissions

1. Complete application and financial forms.

2. Provide the necessary medical information.
    a. Admission from a hospital or another nursing facility

3. Information below is supplied by Social Worker/Case Manager at hospital following request from the Admissions Director
    a. History and Physical
    b. Nurses' progress notes
    c. Chest X-ray, Lab screening results
    d. List of Medications
    e. Admission from a private residence

4. Pre-admission medical form completed by applicant's physician

5. Assessment form completed by a family member

6. The Admissions Committee will make a decision concerning admission based on the above information.

7. Copies of the following must accompany the application form:
    a. One copy of Medicare/Social Security, secondary insurance, PACE (if applicable), Medicare-D Prescription Plan cards
    b. Durable Power of Attorney for Health Decisions and/or Living Will

Saint Joseph Villa
Application

Date of Application: _____

Applicant Name: _____

Home Address:

_____

Street City ST Zip

Phone: _____-_____-_____

Date of Birth: _____/_____/_____ Age _____

Social Security Number: _____ -_____-_____

Religion: _____

Medicare Number and letter: _____

Other Insurance and Claim Number: _____

Marital Status:Single Married Widow(er) Divorced

Do you live alone? Yes No

If no, with whom do you live? _____Relationship _____

Do you have a durable power of attorney? Yes No

If yes, please identify: _____
Name Relationship

_____
Address Phone

Who will be acting as your responsible party? A responsible party is someone who will take responsibility to provide information, but does not assume financial responsibility.

Responsible party Name: _____ Phone# _____

_____
Address Alternative Phone #

Other Family members:

Name:	Relationship:	Phone:	POA – Y/N

Financial Information:

Present Monthly Income:	Amount
Source:	$
Source:	$
Source:	$

Other Assets: (i.e. Real Estate/Stock/Investments)

Description	Value	Names on Account(s):

Liabilities:

Description	Value:	Whose name is the debt in?

Has the applicant transferred any asset (cash, savings, real estate, payments to relative(s), in the last five years from the date of this application? Yes No

If yes, please explain below:

_____

_____

_____

Does the Applicant have a Life Insurance Policy: Yes No

Company _____ Amount $ _____ Cash Surrender $_____

Does the Applicant have a prepaid burial account? Yes No

Funeral Director Name _____

Address: _____
Street City

_____
ST Zip Phone Number

Please note:
This information will be kept strictly confidential. We ask for this information only to assure the proper service and care to our residents. If you are applying for medical assistance, additional detailed information will be required.

Signature of Applicant: _____

Signature of Responsible Party: _____

Signature of POA: _____

Return completed application to Admissions Office -1st floor of Saint Joseph Villa, or by mail to:

Saint Joseph Villa, Admissions Office, 110 W. Wissahickon Avenue, Flourtown, PA 19031.'

Please include supporting documentation with application.

Administration Only

Administration signature: _____

Date application received: _____

Saint Joseph Villa
PRE-ADMISSION MEDICAL FORM

Applicant_____ **Date of Birth** _____

Home Address: _____

_____

Street City ST Zip

Primary Care Physician _____ Telephone _____

Information below and on the reverse side must be completed by the Primary Care Physician

Signature of Physicians completing form**:** _____

Total number of years applicant has been under your care**:** _____

Diagnoses: _____

_____

_____

_____

Medications: _____

_____

_____

_____

Treatments: _____

_____

_____

_____

Medical History:

_____

_____

_____

_____

Systems Review

Please check where appropriate:

Mental Status
Alert _____
Cooperative _____
Calm _____
Lethargic _____
Withdrawn _____
Depressed _____
Agitated _____
Anxious _____
Combative _____
Wanderer _____

Oriented to:
Time _____
Place _____
Person _____

Speech
Normal, Clear _____
Slurred _____
Hesitant _____
Hoarse _____
Dysphasic _____

Neurological System
Normal _____
Pupils; PERRLA _____
Dizziness _____
Numbness _____
Headaches _____
Paraplegia _____
Hemiplegia, left _____
Hemiplegia, right_____

Comments _____
_____
_____
_____
_____

Nutritional Status
Special Diet _____
Recent Weight Gain_____
Recent Weight Loss_____

Eyes
Normal _____
Glasses _____
Contact Lenses _____
Implanted lenses _____
Blind _____
Artificial Prosthesis _____
Discharge _____
Double Vision _____
Blurred Vision _____
Tearing _____
Burning _____
Itching _____
Pain _____
Cataract _____
Sciera Color _____

Ears
Normal _____
Hearing Loss _____
Hearing Aid _____
Tinnitus _____
Vertigo _____
Discharge _____
Pain _____

Nose
Normal _____
Sinusitis _____
Rhinitis _____
Discharge _____
Obstruction _____
Epistaxis _____

Reproductive System

Female:
Irregular bleeding _____
Discharge _____
Vaginal infections _____
Menopause _____
Other _____

Male:
Lesions _____
Prostate Problems _____
Other: _____

Musculoskeletal System
Normal _____
Stiffness _____
Pain _____
Weakness _____
Limited ROM _____
Arthritis _____
Physical Activity _____
No limitations _____
Walks with help _____
Bedridden _____
Falls _____
Walker/Cane/Wheelchair
(circle if applicable)

Mouth and Throat
Normal _____
Dentures, upper_____
Dentures, lower _____
Partial plate _____
Dental Fillings _____
Broken teeth _____
Missing teeth _____
Mouth Sores _____

Systems Review

Please check where appropriate:

Respiratory System
Normal _____
Dyspnea _____
Cough _____
Hemoptysis _____
Pain _____
Orthopnea _____
Breath sounds _____
_____

GU Systems
Normal _____
Frequency _____
Urgency _____
Dysuria _____
Nocturia _____
Incontinent _____
Bleeding _____
Burning _____

Cardiovascular System
Normal _____
Edema _____
Cyanosis _____
Palpitations _____
Extremities:
Regular _____
Irregular _____
Bounding _____
Weak _____
Thread _____
Pedal pulse, right _____
Pedal pulse, left _____

Skin
Rash _____
Bruises _____
Burns _____
Lumps _____
Lacerations _____
Abrasions _____
Scars _____
Pressure ulcers _____

Social History
Tobacco _____
Packs/day _____
Alcohol
Drinks/day _____

Saint Joseph Villa

Judgement Assessment of the Applicant
****to be completed by the family***

Mental Status
_____ Able to follow
and remember instructions

_____ Alert/Clear
_____Occasionally disoriented
_____Noisy
_____ Combative
_____Wandering behaviors

Ambulatory Status
_____Independent
_____Supervised
_____Assisted
_____Dependent
_____Assistive Devices:
_____
_____ Falls

Transfer Status
(refers to ability to move from
chair to bed/bed to chair)
_____Independent
_____ Supervised
_____ Assisted
_____ Dependent

Self-Care Status
_____ Independent
_____Supervised
_____ Assisted
_____ Dependent

Bowel Status
_____ Independent
_____ Bowel program
_____ Incontinent

Bladder Status
_____ Independent
_____ Bladder program
_____ Foley catheter
_____ Incontinent
_____ Wears liners/briefs

Communication Status
_____ Can speak
_____ Language barrier
_____ Aphasia
_____ Hearing loss

Feeding Status
_____ Independent
_____ Set-up
_____ Assistance
_____ Special dietary needs
_____ Gastrostomy/NG tube
_____ Feeding
_____ I.V's
_____ Dependent
_____History of weight loss