APPLICATION FOR: THOBURN VILLAGE
CRIBBS RESIDENTIAL CENTER

31 North Park Avenue, Meadville, PA 16335

Please complete form (one per person) and return to the Marketing Department

INDIVIDUAL INFORMATION

Full Name of Applicant _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Gender ☐ Male ☐ Female Nickname _____

SSN _____ Date of Birth _____ Birthplace _____ Age _____

Status: ☐ Single ☐ Married – Spouse's Name _____ Date _____ ☐ Widowed ☐ Divorced

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No Branch: _____

Are you a Wartime Veteran? ☐ Yes ☐ No What Conflict? _____

Religious Facility _____ Denomination _____

Address _____ Clergy _____

Former Occupation(s) _____

Automobile make _____ Color _____ Year _____ Plate Number _____

CONTACT INFORMATION

Power of Attorney (POA) ☐ Yes ☐ No

Name of POA _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship of POA: ☐ Spouse ☐ Child ☐ Other _____

Email _____

Name of Responsible Party _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Email _____

Person Paying Bills _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Email _____

Continues on Next Page

EMERGENCY CONTACTS

Names and addresses of nearest relatives who may be contacted regarding your health status in the order listed below:

Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

HEALTHCARE INFORMATION

Do you have Advanced Directives? *(Please ŏKŝŏ˺ all that apply, if Yes please attach)*

☐ Do Not Resuscitate ☐ Living Will ☐ Will ☐ Durable POA

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Podiatrist _____ Phone _____

Address _____

Attorney _____ Phone _____

Address _____

Pre-Arranged Funeral? ☐ Yes ☐ No Funeral Home _____

Address _____ Phone _____

If no pre-arrangement, funeral home preference _____

Continues on Next Page

HEALTH CARE INSURANCE

Medicare Number _____

Medicare Part A - Hospitalization Effective Date _____

Medicare Part B - Medical Effective Date _____

Insurance/Supplemental Insurance Information

Insurance Name _____

Insured's ID Number _____ Expiration Date _____

Policy/Group Number _____

BIOGRAPHICAL AND SOCIAL DATA

Needs/Reason for entrance to community _____

Current family situation and living arrangements _____

What are your special interests and hobbies? _____

Fraternal, social or professional organizations in which you hold membership _____

_____

Highest education level: _____

I hereby declare that all information provided herein is true according to by best knowledge and I understand that this information may be reevaluated at the time of entrance to the Wesbury community.

Date _____ _____

Signature of Applicant

_____

Signature of Responsible Party

Wesbury is a continuing care retirement community governed by a 15 member Board of Directors and affiliated with the Western Pennsylvania Annual Conference of the United Methodist Church. Wesbury is organized as a not-for-profit corporation.
Rev. Nov. 2017

CONFIDENTIAL FINANCIAL DATA

Applicant (A) _____ DATE _____

Applicant (B) _____

Monthly Income	Applicant A	Applicant B	Total
Social Security Payment	$	$	$
Pension and Retirement	$	$	$
Veterans Benefits	$	$	$
Annuities	$	$	$
Dividends and Interest	$	$	$
Rental Property	$	$	$
Other Income (specify)	$	$	$
Total Monthly Income	$	$	$

Assets	Joint - Note Area	Applicant A	Applicant B	Total
Checking	$	$	$	$
Savings	$	$	$	$
Certificates of deposit (CDs)	$	$	$	$
Annuities (list type of)	$	$	$	$
Stocks/Bonds	$	$	$	$
Mutual Funds	$	$	$	$
Retirement Funds (IRA, 401K, etc.)	$	$	$	$
Real Estate (specify location)	$	$	$	$
Other (specify)	$	$	$	$
Total	$	$	$	$

Have you gifted any resources in the past 5 years? _____

Veterans Aid and Attendance: Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No

Branch: _____ Are you a Wartime Veteran? ☐ Yes ☐ No What Conflict? _____

Long Term Care Insurance	Applicant A	Applicant B	
Company			
Annual Cost	$	$	
Elimination Period			
Assisted Living Coverage	$ /day	$ /day	Max./# years
Nursing Care Coverage	$ /day	$ /day	Max./# years
In-Home Care Coverage	$ /day	$ /day	Max./# years

Life Insurance

Company _____ Type _____ Policy No. _____

Beneficiary _____

Cash Value _____ Death Benefit Value _____

Continues on Next Page

Monthly Expenses that Continue Once at Wesbury	Applicant A	Applicant B	Total
Auto Insurance	$	$	$
Health Insurance	$	$	$
Life Insurance	$	$	$
Long-term Care Insurance	$	$	$
Prescriptions	$	$	$
Food and Gas	$	$	$
Personal (clothing, travel, entertainment etc.)	$	$	$
Utilities (If House is Unsold)	$	$	$
Donations or Tithing	$	$	$
Other Monthly Expenses (specify)	$	$	$
Total	$	$	$

Outstanding Debt	Applicant A Monthly Payment	Applicant B Monthly Payment	Outstanding Balance	Pay Off Date
Credit Cards				
Real estate (Mortgage)				
Other Loans (vehicle, RV, boat, etc.)				
Other (specify)				
Total				

Notes: _____

_____

_____

_____

Adult Residential Licensing - Documentation of Medical Evaluation (DME)
INSTRUCTIONS FOR USE

Applicable Regulations

§ 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

§ 2600.141(a)(2) - The medical evaluation shall include the following:
(1) A general physical examination by a physician, physician's assistant or nurse practitioner.
(2) Medical diagnosis including physical or mental disabilities of the resident, if any.
(3) Medical information pertinent to diagnosis and treatment in case of an emergency.
(4) Special health or dietary needs of the resident.
(5) Allergies.
(6) Immunization history.
(7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
(8) Body positioning and movement stimulation for residents, if appropriate.
(9) Health status.
(10) Mobility assessment, updated annually or at the Department's request.

§ 2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

§ 2600.141(b)(2) - A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

Homes are PROHIBITED from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.

Adult Residential Licensing - Documentation of Medical Evaluation (DME)

Resident Information	**Evaluation Information**		
Name:	Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date Resident Evaluated:	Date Form Completed:
Date of Birth:			

(1) - General Physical Examination	Height:	Weight:	Pulse Rate:
Blood Pressure:	Temperature:		

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	

FOR ADDITIONAL DIAGNOSES, SEE "DIAGNOSES ADDENDUM" BELOW

(4) Special Health or Dietary Needs

☐ None
☐ This resident **CAN** safely use or avoid poisonous materials
☐ Secured Dementia Care (For SDCU admissions only)
☐ Other - SEE "NEEDS ADDENDUM" BELOW

(6) - Immunization History

Are immunizations current? ☐ Yes ☐ No ☐ Unknown

Td/Tdap Date:	Influenza Date:

(5) - Allergies

☐ None ☐ Unknown ☐ Listed Below:

Other Immunizations (List Date and Type):

(7) - Medications

☐ None

OR SEE "MEDICATION ADDENDUM" BELOW

Ability to Self-Administer Medications - Check all that apply:

☐ Can self-administer - no assistance from others
☐ Can self-administer - assistance to store medications in a secure place
☐ Can self-administer - assistance in remembering schedule
☐ Can self-administer - assistance in offering medications at prescribed times
☐ Can self-administer - assistance in opening container or locked storage area
☐ Can self-administer some medications but not others - See MED. ADDENDUM

OR

☐ Cannot self-administer medications

(8) Body Positioning / Movement

☐ None ☐ Listed Below:

(9) - Health Status

☐ Excellent ☐ Poor
☐ Good ☐ Actively Dying
☐ Fair

Cognitive Functioning

☐ Excellent ☐ Poor
☐ Good ☐ None
☐ Fair

(10) Mobility Needs Assessment	Independent (Mobile) Resident has **no** mobility needs and can evacuate independently in an emergency	Minimal (Mobile) Resident requires **limited** physical or oral assistance to evacuate in an emergency	Moderate (Immobile) Resident requires **moderate** physical or oral assistance to evacuate in an emergency	Total (Immobile) Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons
	☐	☐	☐	☐

Medical Professional Information

By signing below, I certify that:

- I am a physician, physician's assistant or certified registered nurse practitioner whose license to practice is in good standing.
- The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation
- The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600

Medical Professional Name:	**Medical Professional License #:**
Medical Professional Signature:	**Date Signed:**

Documentation of Medical Evaluation (DME) - Addendum Sheet
This sheet may be copied as needed if additional space is required

Resident Information	**Evaluation Information**	
Name:	Date Resident Examined:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if Applicable**
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(4) Needs Addendum

☐ Special Diet - Check all that apply

☐ No Added Sodium
☐ Mechanical Soft Foods
☐ Pureed Foods
☐ Low cholesterol
☐ Heart Healthy
☐ No Concentrated Sweets

Other (describe):

☐ Special Health Needs - Include Description

(7) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

*** Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.**