31 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) _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship of POA: ☐ Spouse ☐ Child ☐ Other _____

Email _____

Name of Resident Representative _____ 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/APPROVED CONTACTS

List those who we may contact in an emergency or whom we may share your health status with.

First Emergency Contact _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work phone _____

Relationship _____ Email _____

Second Emergency Contact _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

Contact _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

Contact _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

Contact _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

HEALTHCARE INFORMATION

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

☐ Do Not Resuscitate ☐ Living Will ☐ Durable POA

Physician _____ 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: _____

HOW DID YOU HEAR ABOUT US?

☐	**Print Ad**	☐	**Direct Mail**	☐	**Radio**	☐	**TV**	☐	**Referred by a Friend**	☐	**Website**	☐	**Other:**

I hereby declare that all information provided herein is true according to my 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 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. FEB. 2024

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 (address)	$	$	$	$
Other (specify)	$	$	$	$
Total	$	$	$	$

Please include documentation proof of income/assets

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				

Have you gifted any resources in the past 5 years in the amount of $500 or more? ☐ Yes ☐ No

If yes, list when and describe the gift: _____

_____

_____

Do you have a Trust? ☐ Yes ☐ No If yes, please include a copy of your trust with this application.

Notes: _____

_____

_____

_____

I certify that all information provided is true and accurate. I/We agree to make all listed resources available, as required, to qualify for and/or pay for the requested housing, care, and/or services at Wesbury.

Date _____

_____
Signature of Applicant

_____
Signature of Applicant

_____
Signature of Responsible Party

Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

INSTRUCTIONS FOR USE

Personal Care Home

Applicable Regulations

§ 2600.141

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 and certification of accuracy 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.

Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

Licensed Setting:
Personal Care Home

Resident Information			**Evaluation Information**		
Name:			Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date of In Person Evaluation:	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.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

For additional diagnoses, see **Diagnoses Addendum** on page 4.

(4) Poisonous Materials	**(5) - Advanced Directives**
☐ This resident CAN safely use or avoid poisonous materials ☐ This resident CAN NOT safely use or avoid poisonous materials	☐ Yes ☐ No Check One: ☐ Full Code ☐ DNR (Do Not Resuscitate)
(6) - Special Health or Dietary Needs	**(7) - Allergies**
☐ None ☐ Special Diet - Check all that apply ☐No Added Sodium ☐Low Cholesterol ☐Heart Healthy ☐Mechanical Soft Foods ☐Pureed Foods ☐No Concentrated Sweets ☐ Respiratory Care Describe: _____ ☐ Wound Care ☐ Other - See **Needs Addendum** on page 4	☐None ☐Unknown ☐Listed Below:

(8) - Medications	(9) - Immunization History	
☐ None **OR** See **Medication Addendum** on page 4	Are immunizations current? ☐Yes ☐No ☐Unknown	
Ability to Self-Administer Medications - Check all that apply: ☐ Can self-administer - no assistance from others. ☐ Can self-administer -assistance to store medication in a secure place ☐ Can self-administer - assistance in remembering schedule. ☐ Can self-administer - assistance in offering medication at prescribed times. ☐ Can self-administer some medications but not others - See **Medication Addendum** on page 4 **OR** ☐ Cannot self-administer medications.	Td/Tdap Date: Type:	Influenza Date:
	Pneumonia Date:	Covid Date:
	TB Test Date:_____ Type: ☐Skin ☐Blood Chest X-Ray Date:_____	
	Other Immunization - (List Date and Type):	

(10) - Body Positioning / Movement - Level of Assistance for Ambulation or Transfers	(11) - Health Status	(12) - Cognitive Functioning (Check All That Apply)
☐ None ☐ Assistive devices and/or wheelchair: Listed: _____ ☐ Supervision ☐ Cueing ☐ One person assist ☐ Two person assist ☐ Assist with repositioning ☐ Assist with turning ☐ Assist with transfers	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Actively Dying	☐ No impairment/Independent ☐ Short term memory deficits ☐ Long term memory deficits ☐ Needs assist with high level decision making ☐ Needs assist with all decision making ☐ Dementia diagnosis ☐ Brain injury

(13) Mobility Needs Assessment (For Ability To Evacuate In An Emergency)	☐ **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

(14) Special Care Needs (For Secure Dementia Care Unit Admissions Only)

Dementia

Does resident require dementia - related care in a secured area?

☐ YES

☐ NO

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 of In Person Evaluation:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(6) Needs Addendum

Other (describe):

(8) 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
					☐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.**

Medical Professional Information

By Signing Below, I certify that:

- ☐ I am a physician, physician 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.

Check One Of The Options Below:

- ☐ The resident's needs can be met safely at the Personal Care Home.
- ☐ The resident is Nursing Facility Clinically Eligible (NFCE). Services to be provided at home or in a nursing facility. The resident's needs CAN NOT be met safely at the Personal Care Home.

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