

Application for Admission



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to superb service
and the values
of dignity, trust,
and independence.*



*Proudly serving
the community
for more than
125 years.*

Application for Admission

**PLAN D
CONFIDENTIAL APPLICATION FOR ADMISSION
(To be completed by Applicant or Power of Attorney)**

The applicant herewith agrees that ANY FALSE OR INCOMPLETE ANSWER OR STATEMENT SHALL BE CAUSE FOR REJECTION OF THIS APPLICATION, AND IF ADMITTED UNDER SUCH FALSE OR INCOMPLETE INFORMATION, THE SAME SHALL BE CAUSE FOR DISMISSAL FROM THE HOME.

GENERAL

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Telephone _____ - _____ - _____ Birth Date _____

Birth Place _____ Military Service _____

Education ___ Elementary ___ High School ___ College ___ Other _____

Occupation _____ Religion _____

Last Employment (where and when) _____

Social Security # _____ Medicare # _____

Supplemental Name and Member # (if applicable) _____

SPOUSE

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Telephone _____ - _____ - _____ Other number _____ - _____ - _____

Date and Place of Marriage _____

Date and Place of Divorce _____

Date and Place of Burial _____

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CHILDREN OR CLOSEST RELATIVE

*Name/Address/Telephone (home, business, cell)
Please use separate sheet if needed.*

1. _____

2. _____

3. _____

EMERGENCY NOTIFICATION

Name _____ Relationship _____
Address _____
(Street) (City) (State) (Zip)
Home _____ Cell _____ Business _____
Email address _____

FINANCIAL POWER OF ATTORNEY *(Must provide a copy to PHM)*

Name _____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
Home _____ Cell _____ Business _____
Email address _____

HEALTH CARE AGENT

Name _____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
Home _____ Cell _____ Business _____

FUNERAL ARRANGEMENTS *(must complete before admission)*

Funeral Home _____ Phone _____
Address _____
(Street) (City) (State) (Zip)

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MEDICAL

Primary Care Physician

Name _____

Address _____
(Street) (City) (State) (Zip)

Telephone number _____ - _____ - _____ Other Number _____ - _____ - _____

Date of Last Visit _____ Years as a patient _____

Specialists (Name / Specialty / Phone / Date of Last Visit)

1. _____
2. _____
3. _____

List Current Health Problems *(Medical records will be required as a part of application)*

Current Medications *(Medical records will be required as a part of application)*

Which of the following activities do you need assistance with?

- _____ Bathing _____ Dressing _____ Feeding
_____ Housekeeping _____ Medication Administration _____ Ambulation

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FINANCIAL Write "n/a" if not applicable.

Has the applicant been required to file federal and state income tax returns?

___ Yes ___ No If yes, please attach copy of the applicant's federal and state income tax returns for the last year filed.

Does anyone other than the applicant have control over the applicant's finances?

___ Yes ___ No If yes, please provide the name, address, telephone number and relationship of the individual.

Name _____ Relationship _____
Address _____ Home Phone _____
_____ Cell Phone _____

Does the applicant have Long Term Care Insurance? ___ Yes ___ No

If yes, please provide the following or attach a copy of the policy.

Insurance Company _____ Policy # _____
Benefit Period (in years) _____ Elimination Period (in days) _____
Maximum Benefit _____
Per Diem rate for Assisted Living 3 care _____ Comprehensive (nursing) care _____

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MONTHLY INCOME SUMMARY

Social Security less Medicare Part B Premium	\$ _____
Total Pension Income	\$ _____
Total Annuity Payments	\$ _____
Other Income	\$ _____
TOTAL \$ _____	

MONTHLY EXPENSE SUMMARY (Only list expenses necessary after admission).

Long-term care insurance premiums	\$ _____
Health insurance premiums	\$ _____
Other insurance premiums	\$ _____
Monthly income tax/withholdings	\$ _____
Monthly prescription costs	\$ _____
Monthly medical fees	\$ _____
Monthly personal expense	\$ _____
TOTAL \$ _____	

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I, _____, **HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND COMPLETE, AND THAT ANY FALSE OR INCOMPLETE STATEMENT DISCOVERED AFTER THE DATE OF THIS APPLICATION WILL BE SUFFICIENT CAUSE FOR MY REJECTION OR TERMINATION.**

Signature

Date

BEFORE MAILING, BE SURE YOU HAVE

1. Filled out application completely.
2. Properly signed and dated application.
3. Included a copy of Power of Attorney.
4. Included a copy of Advance Directive.
5. Most Form
6. Enclosed a check in the amount of \$350.00.
Made check payable to: Presbyterian Home of Maryland, Inc.
(non-refundable processing fee).

RETURN COMPLETED APPLICATION TO:

Presbyterian Home of Maryland, Inc.
400 Georgia Court
Towson, Maryland 21204
Attn: Director of Admissions

Application for Admission

400 Georgia Court
Towson, Maryland 21204
www.presbyterianhomeofmd.org
410-823-4622 | 1-866-483-1552
F: 410-823-0598

