



4227 Manor Drive · Stroudsburg · Pennsylvania · 18360-9422
Phone (570) 992-4172 · Fax (570) 992-7409 or (570) 992-6150

PRE-ADMISSION INFORMATION

PERSONAL INFORMATION

RESIDENT'S NAME: _____

PREFERRED NAME: _____

HOME ADDRESS: _____

OWNS HOME: YES NO

RESIDES IN AN APARTMENT: YES NO RESIDES IN A FACILITY: YES NO

LIVED ALONE: YES NO WITH FAMILY: YES NO

OTHER: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY #: _____ SEX: _____

RELIGION: _____

PASTOR / CHURCH AFFILIATION: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME: _____

MILITARY SERVICE: YES NO BRANCH: _____

EDUCATION LEVEL: _____

FORMER OCCUPATION(S): _____

SPECIAL INTERESTS / HOBBIES / CRAFTS: _____

ADMISSION INFORMATION

ADMISSION DATE: _____

LOC: _____ ROOM # _____

TO BE ADMITTED FROM:

HOME

POCONO MEDICAL CENTER

DATE ADMITTED: _____

GOOD SHEPHERD REHAB – POCONO MEDICAL CENTER

DATE ADMITTED: _____

OTHER: _____

DATE ADMITTED: _____

LEGAL/FUNERAL INFORMATION

POWER OF ATTORNEY: _____

LIVING WILL: YES NO PREPAID BURIAL ACCOUNT: YES NO

FUNERAL DIRECTOR: _____

RELATIVE AND CAREGIVER INFORMATION

NAME	RELATIONSHIP	ADDRESS	PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL INFORMATION

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

OTHER DIAGNOSIS / PROBLEMS: (HOME EQUIPMENT I.E. OXYGEN, CPAP, ETC):

ALLERGIES: _____

SMOKES: YES NO

SKIN CONDITION: _____ CONTINENCE: _____

AMBULATION INFORMATION

INDEPENDENT: YES NO

WITH ASSISTANCE: YES NO WITH WALKER: YES NO WITH CANE: YES NO

WHEEL CHAIR: YES NO BEDFAST: YES NO

BED MOBILITY INFORMATION

INDEPENDENT: YES NO

WITH ASSISTANCE: YES NO TOTAL CARE: YES NO

SLEEPING INFORMATION

AWAKES: _____ (TIME) NAPS: YES NO _____ (TIMES)

BEDTIME: _____ (TIME) OTHER: _____

NEEDS INFORMATION

SELF GROOM: YES NO GROOM W / ASSIST: YES NO TOTAL CARE: YES NO
SELF BATH: YES NO BATH W / ASSIST: YES NO TOTAL CARE: YES NO
SELF DRESS: YES NO DRESS W / ASSIST: YES NO TOTAL CARE: YES NO
SELF FEED: YES NO FEED W / ASSIST: YES NO TOTAL CARE: YES NO

MENTAL STATUS INFORMATION

ALERT: YES NO COMPLIANT: YES NO CONFUSED: YES NO
DEPRESSED: YES NO COMBATIVE: YES NO
PREVIOUS PSYCH ADMISSION: YES NO

IF YES, LIST DATES OF ADMISSIONS: _____

DIET INFORMATION

REGULAR: YES NO SPECIAL (SPECIFY): _____
WEIGHT LOSS / GAIN: _____

PROSTHETIC INFORMATION

PROSTHESIS: YES NO DENTURES: YES NO UPPER LOWER BOTH
GLASSES: YES NO HEARING AID: YES NO

VACCINATION INFORMATION

FLU VACCINE: YES NO PNEUMOVAX: YES NO

THErapy NEEDS INFORMATION

PHYSICAL THERAPY: YES NO OCCUPATIONAL THERAPY: YES NO

RECREATIONAL THERAPY: YES NO SPEECH THERAPY: YES NO

HEARING: _____

PLACEMENT DESIRED/DISCHARGE PLAN

SHORT-TERM REHABILITATION (INTENDING TO RETURN TO PREVIOUS LIVING SITUATION)

LONG-TERM PLACEMENT

UNSURE

NOTES/INSTRUCTIONS: _____

FINANCIAL INFORMATION

PAYER SOURCES FOR: FACILITY DAYS, MEDICARE CO-INSURANCE DAYS, HOSPITAL DAYS,
PRESCRIPTIONS AND/OR ON EXHAUSTION OR DISCONTINUATION OF MEDICARE OR
INSURANCE BENEFITS:

MEDICARE A

POLICY ID: _____ EFFECTIVE DATE: _____

MEDICARE B _____

MEDICARE D (RX INS)

COMPANY: _____ ID #: _____

PACE _____

OTHER RX INSURANCE

COMPANY: _____ ID #: _____

BLUE CROSS/BLUE SHIELD

COMPANY NAME: _____

ID#: _____ GROUP #: _____

OTHER INSURANCE COMPANY

NAME: _____

OTHER INS. ID #: _____ GROUP #: _____

MEDICAL ASSISTANCE FOR LONG-TERM CARE

APPROVED; ACCESS #: _____

PENDING (APPLICATION FILED BUT NOT APPROVED)

CHECK HERE IF YOU REQUIRE AN APPLICATION FOR MEDICAL ASSISTANCE
BENEFITS

PRIVATE PAY

FINANCIAL DATA (APPROXIMATE TOTALS)

ACCOUNTS:

INCOME:

CHECKING ACCOUNTS: _____

SOCIAL SECURITY: _____

SAVINGS ACCOUNTS: _____

PENSIONS: _____

OTHER ACCOUNTS: _____

OTHER INCOME: _____

BILLING ADDRESS

ALL APPLICANTS ARE REQUIRED TO PROVIDE AN ADDRESS FOR CONTACT. APPLICANTS WITH
P.O. BOX #'S, PLEASE INCLUDE A STREET ADDRESS.

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP: _____ PHONE: _____

PRIOR TO FINAL APPROVAL FOR ADMISSION TO *PLEASANT VALLEY MANOR*, THE FOLLOWING VALID AND VERIFIABLE INFORMATION MUST BE PROVIDED TO AND RECEIVED BY THE FACILITY. THESE ITEMS MAY BE MAILED, HAND DELIVERED OR FAXED. PHOTOCOPIES ARE ACCEPTABLE.

GENERAL INFORMATION

- SOCIAL SECURITY CARD
- PHOTO IDENTIFICATION
- MAILING ZIP CODE (ZIP CODE WHERE MEDICARE EXPLANATIONS OF BENEFIT OR EOBS ARE MAILED)

HEALTH INSURANCE INFORMATION

- MEDICARE CARD
- SUPPLEMENTAL INSURANCE CARD
- PRIMARY INSURANCE CARD (IF OTHER THAN MEDICARE)

PRESCRIPTION INSURANCE INFORMATION (IF APPLICABLE)

- MEDICARE PART D CARD
- PACE OR PACE NET CARD
- OTHER RX INSURANCE CARD

IF THIS INFORMATION IS NOT PROVIDED OR IF THE INFORMATION PROVIDED PROVES INVALID, THE APPLICATION FOR ADMISSION TO *PLEASANT VALLEY MANOR* WILL BE DENIED UNTIL SUCH TIME THE INFORMATION IS PROVIDED AND/OR VALIDATED.

PLEASANT VALLEY MANOR, INC 227 MANOR DRIVE STROUDSBURG PA 18360
BUSINESS OFFICE PHONE: (570) 992-4172 BUSINESS OFFICE FAX: (570) 992-0324