

FRIENDS HOME in KENNETT
147 West State Street • Kennett Square, PA 19348
Phone: 610-444-2577 Fax: 610-444-2856

APPLICATION FOR ADMISSION

Today's Date : _____

Name: _____ Birth Date: _____

Present Address:

City: _____ State: _____ Zip Code: _____

Telephone: _____ Desired Entrance Date _____

Email: _____

Church Affiliation: _____ If Friend, what Monthly Meeting: _____

Primary Responsible Party:

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: Code _____

Home Phone# _____ Work# _____ Cell# _____

Email: _____

Power of Attorney: Yes No Who is the POA? _____

Living Will: Yes No

List names and addresses of others to contact in the event of an emergency:

Name	Address	Telephone	Relationship
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____

Health Insurance Information

Social Security # _____ Medicare # _____

Secondary Insurance _____ Group # _____ Agreement # _____

TOTAL ASSETS \$ _____

SOURCES OF MONTHLY INCOME

Social Security: \$ _____/mo.
Pension Income: \$ _____/mo.
Annuity: \$ _____/mo.
Investment Income: Name of source(s) \$ _____/mo.

Total Monthly Income: \$ _____/mo

Financial adviser's Name/Trust Officer, Address and phone number (if applicable):

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

I hereby certify that the information supplied herein is complete and accurate to the best of my knowledge and I agree to provide whatever information deems necessary to verify my financial position. I also understand that my approval for residency at the Friends Home in Kennett/Linden Hall is predicated upon the accuracy of this information, and said approval may be revoked at any time should any of the information prove to be substantially false.

Signature of Resident or POA

Date

PERSONAL HISTORY

Where have you lived during most of your life? _____

Do you currently live alone? Yes No

If not, with whom do you live? _____

Why do you wish to become a resident? _____

Have you ever applied to, or been admitted or rejected by, another facility?

Yes No If yes, please explain _____

What are your hobbies/interests? _____

Do you drive an automobile? Yes No If Yes, Make _____ Model _____

List anyone you know who currently lives here: _____

Do you need assistance with walking? No Device Cane Walker

Do you need help with daily activities, such as dressing, bathing, or taking medications?

Yes No If yes, please explain _____

Have you ever been treated for mental illness? Yes No If yes, please give particulars:

List name and addresses of your Physicians:

Name

Address

Phone#

Family Physician: _____

Cardiologist: _____

Orthopedic: _____

Dentist: _____

Ophthalmologist: _____

Other: _____