

Kaysim-Court Manor

A Personal Care Home Residence

5909-19 Wayne Ave.
Philadelphia, PA 19144
Phone: (215) 849-8143
Fax: (215) 951-9651
kcmpch4@gmail.com

Date Issued
_____ 20 _____
Date Received
_____ 20 _____

APPLICATION FOR ADMISSION

The undersigned hereby applies for admission as a resident to Kaysim-Court Manor and agrees, if admitted, to comply with all current and future policies and procedures of Kaysim-Court Manor.

Rental Unit Requested: 1 Occ. Bedroom 2 Occ. Bedroom 3 Occ. Bedroom

PERSONAL INFORMATION

Applicant's Name		Resided at Kaysim before? () Yes () No		What Year?
Address		City, State	Zip	
Telephone Number		Date of Birth	Place of Birth	Age
Gender () Male () Female		Social Security Number		
Present Housing (apartment, private home, personal care home, boarding home, etc.)				
Facility Name, if any		Date of Admission	Contact/Title	Telephone/Ext.
Currently Hospitalized? () Yes () No		If yes, Hospital Name	Contact/Title	Telephone/Ext.
Fax Number		Date of Admission	Reason for Admission	
Currently In Nursing Home? () Yes () No		If yes, Facility Name	Contact/Title	Telephone/Ext.
Fax Number		Date of Admission	Reason for Admission	
Currently Receiving Services from Agency (behavioral health, intellectual disability, senior center, drug & alcohol, etc.) () Yes () No If yes, complete below				
Agency Name	Type of Service Receiving	Contact/Title	Telephone/Ext.	
Agency Name	Type of Service Receiving	Contact/Title	Telephone/Ext.	
Date Housing Required				

MONTHLY INCOME

Payee/Payer Name (person/agency responsible for rent payments)			Relationship
Address	City, State	Home Telephone	Work Telephone
Social Security Amount	SSI Amount	Veterans Amount	Veterans Admin. Claim Number
Pension Amount	Pension Name	Pension Claim Number	Pension Address
Income from Savings	Bank	Account Number	Bank Address
Income from Savings	Bank	Account Number	Bank Address
Other Income Amount	Source	Account Number	Address

Other Income Amount	Source	Account Number	Address
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MARITAL STATUS Applying as couple <input type="checkbox"/> Yes <input type="checkbox"/> No			
I am () Single () Married () Widowed () Divorced () Separated			
Spouse's Name	Address	City, State	Zip
Spouse's Telephone Number	Spouse's Present Housing (apartment, private home, personal care home, etc.)		
Date of Birth	Age	Social Security Number	Place of Birth

EMERGENCY CONTACT/DESIGNATED PERSON			
1st Contact: Name	Address	City, State	Zip
Relationship	Home Telephone	Cell	Work Telephone
2nd Contact: Name	Address	City, State	Zip
Relationship	Home Telephone	Cell	Work Telephone
3rd Contact: Name	Address	City, State	Zip
Relationship	Home Telephone	Cell	Work Telephone

PERSONAL PROPERTY AND FINANCIAL ASSETS				
Cash on Hand	Government Bonds		Other Securities	
Notes or Mortgages	Held By		Address	
Bank Account Type	Balance	Bank	City	Account Number
Bank Account Type	Balance	Bank	City	Account Number
Certificates of Deposit	Balance	Bank	City	Account Number
Individual Retirement Accounts	Balance	Bank	City	Account Number
Other Property or Asset (specify type, value and location)				

PSYCHOLOGICAL/PHYSIOLOGICAL/BEHAVIOR HEALTH (use additional paper, if needed)			
() Alcohol Abuse	Current?	() Yes () No	If no, how long was clean? _____
() Drug Abuse	Current?	() Yes () No	If no, how long was clean? _____
() Mental Health	Diagnosis Type: _____		
() Mental Retardation	() Mild	() Severe	
() Obsessive Compulsive Disorders, specify type: _____			
() Depression, specify type: _____			
() Chain Smoker			
() Other: _____			
Psychiatrist Name	Company/Agency	Address	Telephone/Ext.
Therapist Name	Company/Agency	Address	Telephone/Ext.
Other Name/Title	Company/Agency	Address	Telephone/Ext.

- | | |
|---|---|
| <input type="checkbox"/> Allergies, specify _____ | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Use (smoker) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy (Seizures) |
| <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Urinary Tract Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Gastrointestinal D/O |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Weight Loss-significant |
| <input type="checkbox"/> Cancer, specify _____ | <input type="checkbox"/> Weight Gain-significant |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Decubitus Ulcers | <input type="checkbox"/> Heart Trouble, specify _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diet Restrictions, specify _____ | <input type="checkbox"/> Skin Problems, specify _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Brain Damage, explain _____ |
| | <input type="checkbox"/> Other, specify _____ |

Medical Doctor Name	Company/Agency	Address	Telephone/Ext.
Specialist Name	Company/Agency	Address	Telephone/Ext.

EQUIPMENT USED

- | | |
|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Prosthetic Device |
| <input type="checkbox"/> Glasses/Contact Lens | <input type="checkbox"/> Respiratory Equipment |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Walker |
| | <input type="checkbox"/> Other _____ |

BURIAL PREPARATIONS

**Kaysim-Court Manor does not assume responsibility for burial.
Next of kin may make all arrangements and assume all expenses.**

Reserved Plot? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what cemetery
Monument	Other Information
Pre-paid Funeral Arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of undertaker
Special Instructions	

In order to process this application, you must provide a copy of each of the following that applies:

- | | |
|--|--|
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Living Will |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Durable Power of Attorney for Health Care |

- Proof of Monthly Income (award letter, income statement or copy of check(s))

Certification

I represent that each and every statement above set forth, including any accompanying documents, is true and that I have read this application or had it read to me and that it has been fully explained to me.

Signature of Application/Mark

Witness

If Applicant's Signature is by Mark, Second Witness

Responsible Parties

Responsible parties including: All children, spouse, and other relatives, guardian, healthcare professionals or interested parties are to sign below. Each of the undersigned, being either husband or wife, child, or other relatives, interested friends or healthcare professionals of the above named applicant, does hereby request his or her admission to Kaysim -Court Manor. The undersigned also represent that the information set forth in this application is true to the best of his or her knowledge.

Signatures: _____

For Office Use Only

Above application and all necessary signatures are complete and application is approved for further processing.
Date _____ Office Personnel _____ Fee _____

Kaysim-Court Manor

Criteria for Admission

Date: _____

Proposed Residents Name: _____

Referral Source Name: _____

Referral Source Email: _____

Referral Source Phone Number: _____

Each Category Below Must Be Reviewed And Checked

___ **DME And MA-51 Attached**

___ **English Speaking**

___ **Mobility**

- Able to independently exit building within 2 minutes
- Does not require a wheelchair for mobility

___ **Physical/Medical Criteria**

- Continent of bowel, no colostomy
- Continent of bladder or able to independently manage incontinence, including changing and disposing of undergarments
- Does not require oxygen
- Current with COVID vaccinations as eligible
- Free from open sores or wounds
- No recent indication of or care planning for fall risk
- Free from communicable disease that requires heightened regulatory compliance to maintain an infection free environment

Kaysim-Court Manor

Criteria for Admission cont..

- No history of recreational drug use within the last year
- No significant hearing or vision impairment (Kaysim-Court Manor is not certified to manage those individuals)

_____ Cognitive Status Criteria

- Reasonably alert and oriented with no diagnosis of progressive dementia
- Independent to leave and to return to site without an escort – no history of wandering

_____ Behavioral Criteria

- Willing to be compliant with all Rules and Regulations for Kaysim-Court Manor i.e., agree to take medications as prescribed, shower at least 3x a week
- No recent suicidal/homicidal attempts or current ideations of such
- No history or charges for assault, battery, or arson
- No history or charges for sexual violence, molestation, or coercion – Free from any designation as a sexual predator

_____ Financial

- Willing to allow administration at Kaysim-Court Manor to serve as representative payee for all income
- Willing to participate in all necessary conversations with Aging/County Assistance Office/Social Security Administration to process application for eligibility for State Supplement

Kaysim-Court Manor Admission

INSURANCE INFORMATION		
<u>The following information is important and must be completed.</u>		
Medicare Number (plan A, B or both) and provider	Group Number	Service
Medicaid Provider	Medicaid Number	Service
Address of Medicaid Plan	City, State	Zip
Other Hospitalization Plan	Group Number	Service
Address of Plan	City, State	Zip
SPOUSE INSURANCE INFORMATION		
<u>The following information is important and must be completed.</u>		
Medicaid Provider	Medicaid Number	Service
Address of Medicaid Plan	City, State	Zip
Other Hospitalization Plan	Group Number	Service
Address of Plan	City, State	Zip Code

