Dear Friend,

Thank you for your interest in our assisted living facility, the Abrams Residence. Our residents are individuals who cherish their independence, but who have reached a time in their lives when they need or desire assistance with activities of daily living.

I have enclosed a brochure describing the Abrams Residence and the services we offer. Also included are an application, health questionnaire to be completed by your physician, and a financial information form.

The decision to move to a new residence can be very stressful. Our staff is here to help ease this process in any way we can. Please call me at (609) 883-5391, Ext 305 for additional information or a personal tour.

Sincerely,

Richard Goldstein

Richard Goldstein
Executive Director

Enc.

Greenwood House
SKILLED NURSING | ASSISTED LIVING
HOMECARE SERVICES | REHABILITATION
HOSPICE CARE | KOSHER MEALS ON WHEELS

Abrams Residence
Assisted Living
Application for Admission

Please Complete and Return to:
Greenwood House
53 Walter Street, Ewing, NJ 08628

1. Name:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2. Present Address:_____
Street City State Zip

Telephone:_____ Years at Present Address: _____ Religion: _____

If Less Than 2 Years, Previous Address
_____

4. Date of Birth_____ Age_____ Sex ____ Birthplace _____Occupation _____

5. Medicare #_____ Social Security#_____ Medicaid#_____

Other Insurance (Name)_____ Policy #_____

Group # _____ Subscriber _____Phone #_____

Name & Address of Spouse (if Living)
_____

6. With Whom Are You Now Living? Name_____ Relationship _____

_____
Street City State Zip Home Phone #

7. Names and Addresses of Primary Contacts:

1) Name: _____ Relationship: _____

_____
Street City State Zip Home Phone #

_____
Cell Phone # Work Phone # Email Address

2) Name: _____ Relationship: _____

_____
Street City State Zip Home Phone #

_____
Cell Phone # Work Phone # Email Address

3) Name: _____ Relationship: _____

_____
Street City State Zip Home Phone #

_____
Cell Phone # Work Phone # Email Address

10. Has a durable *Power of Attorney* been designated? ☐ Yes ☐ No

If yes, name of designee _____Phone #_____

11. Has a durable *Financial Power of Attorney* been designated? ☐ Yes ☐ No

If yes, name of designee _____Phone #_____

12. Has a durable *Medical Power of Attorney* been designated? ☐ Yes ☐ No

If yes, name of designee _____Phone #_____

ASSETS:

Name & Address of Bank: _____ Balance: _____

Account: ☐ Single ☐ Joint Type: ☐ Checking ☐ Savings

Name of Bank: _____ Balance: _____

Account: ☐ Single ☐ Joint Type: ☐ Checking ☐ Savings

Stocks & Bonds:

Name: _____ Estimated Value: _____ ☐ Single ☐ Joint

Name: _____ Estimated Value: _____ ☐ Single ☐ Joint

Name: _____ Estimated Value: _____ ☐ Single ☐ Joint

Real Estate:

1) Property Address:

_____

Estimated Value: _____ ☐ Single ☐ Joint Is property currently on the market? ☐ Yes ☐ No

2) Property Address:

_____

Estimated Value: _____ ☐ Single ☐ Joint Is property currently on the market? ☐ Yes ☐ No

Other assets (please describe and whether ownership is single or joint):

_____**TOTAL ASSETS: $**_____

Liabilities (Please describe):_____**TOTAL LIABILITIES: $**_____

Income (Monthly):

Social Security: $_____ Annuities: $_____ Interest Dividends: $_____

Pension: $_____ Other: $_____Other: $_____**Total Monthly Income: $**_____

How do expect to pay for care now? _____In 2 Years? _____

Thank you for completing this application. A nonrefundable $100.00 application fee must accompany this application. In addition, a refundable $1,000.00 deposit, which can be applied to your first month's rent, is also required at this time.

Applicant's Signature _____ Date _____

Signature of responsible party _____ _____ Relationship to applicant _____
Date

We confirm that the above statement is complete and correct:

_____ _____ _____ _____
Signature of Applicant Date Signature of person completing form for applicant Date

ABRAMS RESIDENCE
50 Walter Street, Ewing, NJ 08628
Phone 609-883-5391 Fax 609-530-1635

Abrams Residence

Assisted Living

Greenwood House

SKILLED NURSING | ASSISTED LIVING
HOMECARE SERVICES | REHABILITATION
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Resident: _____ Apartment # _____

Admission Date: _____ Admitted From:_____

Emergency Contact #1: _____ Cell #: _____

Home #: _____ Work #: _____ Relation: _____

Emergency Contact #2: _____ Cell #: _____

Home #: _____ Work #: _____ Relation: _____

Please provide copies of all:

☐ Social Security ☐ Medicare ☐ Medicaid ☐ Other Insurance

☐ Living Will ☐ Power of Attorney ☐ Advanced Directives

Primary Physician:
_____Phone#:_____

Address: _____ Fax#: _____

Dentist Name: _____ Phone #: _____

Address: _____ Fax#: _____

Specialists:
Name: _____ Specialty:_____
Phone#:_____

Address:_____ Fax#:_____

Name: _____ Specialty:_____
Phone#:_____

Address:_____ Fax#:_____

Pharmacy:
_____Phone#:_____

Please choose hospital of choice in case of a medical emergency:

____St. Francis Medical Center ____CHS/Mercer Campus ____CHS/Fuld Campus ____Princeton Medical Center

____Robert Wood Johnson ____ Other: _____

Funeral Home Information:

Name:_____Phone#:_____

Address:_____

Greenwood House

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ABRAMS RESIDENCE
ASSISTED LIVING

SCHEDULE A

Basic Services:

- **2 Bedroom** **$5,410 per person or $10,820 per couple**
- **1 Bedroom (Model 1)** **$6,060 per person**
- **1 Bedroom (Model 2)** **$6,268 per person or $9,739 per couple**

The Basic Monthly Charge includes the following Basic Services listed below:

- Personal Care services each day
- Three meals served restaurant style
- Snacks available 24 hours per day
- Housekeeping services 3 times per week
- Three loads of personal laundry each week
- Linen and towel services
- Scheduled local transportation to market and bank
- One trip per month to a local physician's office
- Activities, cultural and religious programs and social events
- Wellness Program
- Maintenance of apartments and grounds
- Emergency call and response service monitored 24 hours per day
- 24 hour staffing
- Supervision of and medication administration
- Utilities

Personal Assistance Services and Additional Charges:

The following Personal Assistance Services are available at the designated amounts, which amounts are payable **in addition to the Basic Monthly Charge:**

Additional Services:

Guest Meals:	
Lunch	$8.00
Dinner	$8.00
Catering Service /Party Planning	Varies by Menu
Barber and Beauty Shop	Schedule in Resident Handbook
Personal Escort (when available)	$22.00 per hour (1 hour minimum)
Scheduled Transportation Other than to market, bank or physician	$20.00 per hour
Unscheduled Transportation Service	$20.00 per hour
Key Replacement – Apartment or Mailbox Key	$10.00 each
Outside Activities Restaurant, Movies, etc.	Arranged through Activity Department
Telephone Service	As billed by Telephone Company
Cable Television Service	As billed by Cable Carrier
Medical supplies and medications	Varies by Item

Greenwood House

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ABRAMS RESIDENCE 50 WALTER STREET EWING, NJ 08628
PHONE: 609-883-6058 FAX: 609-883-0177

NAME: _____ EXAM DATE: _____

HISTORY: DOB: _____

_____ARTHRITIS
_____ANXIETY
_____BLOOD DISORDER
_____CANCER
_____CIRCULATORY
_____DEMENTIA
_____DEPRESSION
_____DIABETES
_____DIGESTIVE/GI
_____EYE DISORDER
_____HYPERLIPIDEMIA
_____HYPERTENSION
_____HYPOTHYROIDISM
_____PARKINSONS
_____RENAL DISEASE
_____RESPIRATORY
_____URINARY
_____OTHER PSYCHIATRIC DISEASE
Specifics: _____

DRUG ALLERGIES _____

FOOD/SEASONAL ALLERGIES: _____

DIET: _____REGULAR _____NAS _____NCS _____LOW FAT _____FLUID RESTRICT _____OTHER: _____
(LIST)

COMMUNICABLE DISEASE INFORMATION:

DATE OF PNEUMOVAX _____ DATE OF INFLUENZA VACCINE _____

**DATE AND RESULTS OF MOST RECENT MANTOUX TUBERCULIN SKIN TEST

_____

IF TB SKIN TEST RESULT IS POSITIVE- 10 MM OR GREATER, 5 MM IN HIV POS, OR EXHIBITING ANY TB SYMPTOMS, PLEASE RESPOND GIVE
DATE OF LAST CHECK X-RAY/RESULTS _____

BASED ON THE ABOVE INFORMATION, IS THIS PERSON FREE OF COMMUNICABLE TB? _____ YES _____ NO

INFORMATION REQUIRED BY N.J. STATE AND NEEDED FOR ADMISSION

PHYSICAL: _____ HEIGHT _____ WEIGHT _____ B/P _____ P _____ RESP _____ TEMP

VISION/WEARS GLASSES _____
HEARING/WEARS HEARING AIDS _____
DENTAL/WEARS DENTURES _____

HEART: _____ PACEMAKER/DEFIB HOW OFTEN MONITORED _____

RESPIRATORY: _____ REQUIRES OXYGEN (TO WHAT EXTENT) **PRESCRIPTION REQUIRED FOR OXYGEN OR NEBULIZERS:** _____

BLADDER/PROSTATE: _____ CONTINENT _____ INCONTINENT _____ REQUIRES DEPENDS/PULLUPS
_____ SP TUBE/FOLEY CARE REQUIRED _____

BOWEL: _____ COLOSTOMY CARE REQUIRED _____

_____ CONTINENT _____ INCONTINENT _____ REQUIRES DEPENDS/PULLUPS

ABLE TO BE INDEPENDENT WITH BLADDER OR BOWEL CARE: _____ NEEDS ASSITANCE _____

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PG 2 NAME _____ DOB _____

MOBILITY: JOINT/EXTREMITIES _____

_____

AMBULATION: _____ INDEPENDENT _____ CANE _____ WALKER _____ WHEELCHAIR _____ NEEDS ASSIST

_____ ABLE TO TRANSFER SELF IN AND OUT OF CHAIR _____ NEEDS ASSIST

_____ ABLE TO TRANSFER SELF IN AND OUT OF BED _____ NEEDS ASSIST

OTHER INFORMATION REGARDING CARE: _____

_____

MENTATION: _____ ALERT _____ ORIENTED (1) (2) (3) _____ FORGETFUL _____ GUIDANCE/REMINDERS

IS THERE A TENDENCY TO WANDER? _____ AGITATION _____ AGGRESSIVE _____

IS THE RESIDENT A DANGER TO HIM/HERSELF OR OTHERS? _____

IS THERE A TENDENCY FOR SKIN TEARS/WOUNDS? _____

HISTORY OF DRUG ADDICTION/ETOH INTAKE? _____

WAS OR IS A SMOKER? _____

ARE ALCOHOLIC BEVERAGES CONTRA-INDICATED WITH MEDS? _____

ABLE TO ADMINISTER OWN MEDS? _____

DOES YOUR PATIENT HAVE: _____ LIVING WILL _____ DNR

CAN YOUR PATIENT'S NEEDS BE MET IN AN ASSISTED LIVING FACILITY? _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PHONE _____ FAX _____

OFFICE ADDRESS _____

PRINTED PHYSICIAN'S NAME _____

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PG 3 NAME _____ DOB _____

WE MUST HAVE PRESCRIPTIONS FOR ALL MEDICATIONS TAKEN BY YOUR PATIENT INCLUDING OXYGEN. THIS INCLUDES OVER THE COUNTER AND PRN MEDICATIONS. IF PHYSICAL THERAPY IS RECOMMENDED WE WILL NEED A PRESCRIPTION.*PLEASE PRINT NEATLY TO AVOID ERRORS*****

MEDICATION	DOSAGE/FREQUENCY	ASSOCIATED DIAGNOSIS