



APPLICATION FOR RESIDENCY

GENERAL INFORMATION

Resident's Name _____ Date _____

Current Address: _____

Telephone: () _____ Email Address _____

Date of Birth: _____ Sex: _____

Marital status: () Married () Divorce () Single () Separated () Widow

Name of Spouse (if living): _____

Name of Living Children: _____

Address: _____ Telephone number: _____

Social Security No. _____ Medicare No. _____

65 Special Coverage Co. _____ No. _____

Pace Card No. _____ Effective Date: _____

Unit type & Number Reserved: _____

Furniture to be left in unit: _____

Move- In Date Projected: _____ Actual: _____

Reservation deposit received: _____ Check No. _____

Staff Making Reservations: _____

Hospital of Choice: _____

Responsible Party: _____

Address: _____ Telephone No. _____

Sayre Personal Care Center

1001 N. Elmer Ave., Sayre, PA 18840

Phone: 570-888-2858 | Fax: 570-888-2423 | Email: manthony@seniorhealthpa.com

www.seniorhealthpa.com



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Is anyone other than yourself authorized to handle your financial and personal matters? YES NO

If yes, please give his/her name, address, telephone number, and indicate if they have Power of Attorney?

Amount of Finances available? _____

Bank name, Telephone number and type of account:

Physician's name: _____ Telephone: _____

Will the physician visit resident at Sayre Personal Care Center? YES NO

Person to contact in emergency:

Name: _____ Telephone: _____

Address: _____ Telephone: _____

Ambulance service used: Name, Address and telephone Number:

Your religious preference: _____ Church: _____

Name of Clergy Person: _____ Telephone: _____

Pervious occupation: _____

Are there special concerns, fear habits or need which would help us work more effectively with the resident?

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How did you hear about us?

Newspaper TV Radio Hospital referral

Social Media Website Google

Social Worker Agency referral Other

Referred by: _____

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