

# APPLICATION FOR ADMISSION

Date Received: \_\_\_\_\_

Name: \_\_\_\_\_ Prefers to be called: \_\_\_\_\_

Current Address: \_\_\_\_\_

Previous Address: \_\_\_\_\_

If medical facility, facility name/address: \_\_\_\_\_

## HISTORICAL INFORMATION

Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Religion: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Names/Addresses of Sisters and Brothers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names/Addresses of Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Children: \_\_\_\_\_ Number of Grandchildren: \_\_\_\_\_

Primary Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address if different from above: \_\_\_\_\_

Telephone number (home): \_\_\_\_\_ Telephone number (work): \_\_\_\_\_

## EMPLOYMENT/EDUCATION INFORMATION:

Former Occupation: \_\_\_\_\_

Highest Level of Education completed: \_\_\_\_\_

Other Languages spoken: \_\_\_\_\_

## OTHER INFORMATION

Hobbies and Interests: \_\_\_\_\_

Special Talents: \_\_\_\_\_

## DIETARY/HEALTH INFORMATION

Any Special Diet Requirements: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Loss of loved one in the past year? \_\_\_\_\_

Are there any emotional problems? (depression, anger, mood changes)  Yes  No

If yes, please explain: \_\_\_\_\_

Does Applicant prefer  Being Alone  Being with a group  Quiet Lifestyle  Active Lifestyle

Primary care physician: \_\_\_\_\_

Does the applicant require any assistance with any of the following:

Bathing  Dressing  Medication Supervision  Personal Hygiene

Are there any problems with incontinence?  Bladder  Bowels

Does Applicant wear pads or garments for incontinence?  Never  Always

Please let us know how you heard about us \_\_\_\_\_

**FINANCIAL INFORMATION**

In order to process your application, the following information is needed. The information you supply is strictly confidential and allows us to assist you in the financial planning of your care.

Payment Method: Private \_\_\_\_\_ Medicaid (Title#19) \_\_\_\_\_

Name/Address of person responsible for your bills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Income Source: Social Security \$ \_\_\_\_\_ monthly  
Pension \$ \_\_\_\_\_ monthly  
VA Benefits \$ \_\_\_\_\_ monthly  
SSI \$ \_\_\_\_\_ monthly  
Interest Income \$ \_\_\_\_\_ monthly  
Other \$ \_\_\_\_\_ monthly

Total funds available for living expenses: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**INSURANCE INFORMATION**

Medicare Number: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Caseworker: \_\_\_\_\_

Is application pending:  Yes  No

Phone number: \_\_\_\_\_

Medical Insurance: Company: \_\_\_\_\_

Enrollment #: \_\_\_\_\_

Other Insurance: Company: \_\_\_\_\_

Enrollment #: \_\_\_\_\_

Life Insurance: Company: \_\_\_\_\_

Enrollment #: \_\_\_\_\_

**OTHER FINANCIAL INFORMATION**

Do you have a prepaid burial account:  Yes  No

If so, which funeral home? \_\_\_\_\_

Has a legal guardian or conservator been appointed by a court?  Yes  No

If so, name of conservator: \_\_\_\_\_

Please provide the following documents for photocopies:

- 1. Medicare card
- 2. Social security card
- 3. Insurance card
- 4. Living Will documents
- 5. Power of Attorney documents
- 6. Conservatorship documents

**Responsibility Agreement**

*I agree to supply furnishings and to bring an appropriate amount of clothing and personal belongings. I understand that every resident is required to have a telephone in their room and that I will be responsible for its installation and monthly fees. I agree to abide by the discharge policies of the Home and upon the advice of the personal physician and/or the Administrator, I will move my \_\_\_\_\_ to a more suitable facility. I agree to pay the monthly fee on or before the first (1st) day of each month. I understand that the rate is subject to change at any time upon thirty (30) days notice.*

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

