Admission Application

Please provide the requested information below in order for your application to be considered for admission.

Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Marital Status: _____

Physician: _____ Physician Telephone #: _____

Address: _____ Fax #: _____

Other Physicians or Specialists: _____

Medicare #: _____

Other Insurance: _____

Emergency Contact Person: _____

Address: _____ Telephone #: _____

Relationship: _____

MEDICAL INFORMATION

Medical Diagnosis: _____

Allergies: _____

Current Medications: _____

_____

_____

Do you have any of the following?

☐ Power of Attorney ☐ Guardian ☐ Living Will ☐ DNR ☐ Durable Power of Attorney for Healthcare

If yes, who? _____

INCOME

Social Security: _____ per month

Supplemental Security: _____ per month

Retirement Pension: _____ per month

Other Income: _____ per month

ASSETS

Bank: _____

Address: _____

_____

Type of Account: _____

Bank: _____

Address: _____

_____

Type of Account: _____

Do you own your own home? _____

Religion: _____

Do you have prepaid funeral arrangements? _____ If yes, where? _____

FUNCTIONAL ASSESSMENT

Do you need assistance with any of the following?

☐ Bathing ☐ Hygiene ☐ Dressing ☐ Mobility ☐ Eating ☐ Toileting

Have you had any recent falls? _____ If yes, when? _____

MENTAL STATUS

Please choose from the following:

☐ Oriented ☐ Mild Impairment ☐ Moderate Impairment ☐ Heavy Impairment ☐ Severe Impairment

Please describe current living situation and reason for seeking admission: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Applicant: _____ Date: _____

Who Should We Call In Case Of Emergency?

Name: _____ Phone Number(s): _____

_____