

## APPLICATION FOR ADMISSION

**Person filling out the application**

**Date** \_\_\_\_\_

Name of Resident: \_\_\_\_\_

Person Inquiring \_\_\_\_\_

Present Location & Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

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

Phone # : \_\_\_\_\_

E-mail Address: \_\_\_\_\_

List any previous Nursing Home/Hospital Stays: \_\_\_\_\_

Current Physician: \_\_\_\_\_

Physician After Admission: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Will Patient be eligible for Medicare Skilled? \_\_\_\_\_ Will Patient be eligible for Medicaid? \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

Social Security # \_\_\_\_\_

Private Insurance Name: \_\_\_\_\_ #: \_\_\_\_\_

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

Is Patient a Community Care member? \_\_\_\_ # \_\_\_\_\_

Mark appropriate spaces with Yes or No.

	Yes	No		Yes	No		Yes	No
Alert _____	<input type="checkbox"/>	<input type="checkbox"/>	Ambulatory _____	<input type="checkbox"/>	<input type="checkbox"/>	Continuous oxygen _____	<input type="checkbox"/>	<input type="checkbox"/>
Slightly Forgetful _____	<input type="checkbox"/>	<input type="checkbox"/>	Walks with Assistance _____	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Treatments _____	<input type="checkbox"/>	<input type="checkbox"/>
Confused _____	<input type="checkbox"/>	<input type="checkbox"/>	Walker _____	<input type="checkbox"/>	<input type="checkbox"/>	Smokes _____	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn _____	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair/Geri Chair _____	<input type="checkbox"/>	<input type="checkbox"/>	Still Drives _____	<input type="checkbox"/>	<input type="checkbox"/>
Comatose _____	<input type="checkbox"/>	<input type="checkbox"/>	Chair bed rest _____	<input type="checkbox"/>	<input type="checkbox"/>	Bed sores _____	<input type="checkbox"/>	<input type="checkbox"/>
Wanders _____	<input type="checkbox"/>	<input type="checkbox"/>	Total bed rest _____	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness _____	<input type="checkbox"/>	<input type="checkbox"/>
Require Restraints _____	<input type="checkbox"/>	<input type="checkbox"/>	Feeds self _____	<input type="checkbox"/>	<input type="checkbox"/>	Exhibits inappropriate Behavior _____	<input type="checkbox"/>	<input type="checkbox"/>
Sociable _____	<input type="checkbox"/>	<input type="checkbox"/>	Eats with Assistance _____	<input type="checkbox"/>	<input type="checkbox"/>	Noisy _____	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent _____	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing Problems _____	<input type="checkbox"/>	<input type="checkbox"/>			
Uses briefs _____	<input type="checkbox"/>	<input type="checkbox"/>	Tube feeding _____	<input type="checkbox"/>	<input type="checkbox"/>			
Catheter _____	<input type="checkbox"/>	<input type="checkbox"/>	Needs Therapy _____	<input type="checkbox"/>	<input type="checkbox"/>			
Colostomy _____	<input type="checkbox"/>	<input type="checkbox"/>	Uses Oxygen at times _____	<input type="checkbox"/>	<input type="checkbox"/>			

Allergies: \_\_\_\_\_

Special Equipment: \_\_\_\_\_

Treatments: \_\_\_\_\_

Describe Appetite: \_\_\_\_\_

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

Current weight: \_\_\_\_\_

Can the patient bear his/her own weight to stand?: \_\_\_\_\_

Date of last fall: \_\_\_\_\_ # of falls in last year: \_\_\_\_\_

Has the Patient ever been convicted of a sexual crime? \_\_\_\_\_





**PLEASE SIGN BELOW:**

I hereby warrant and represent that the information provided is accurate and complete. I understand that the nursing facility will rely upon the accuracy and completeness of the above information in making a decision. Any false information presented could be grounds for discharge from this facility.

\_\_\_\_\_  
Resident's or Responsible Party's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financial Guarantor's Signature

\_\_\_\_\_  
Date