

APPLICATION FOR ADMISSION

Legal Name: _____ Preferred Name/Nickname: _____

Address: _____

Telephone () _____ Cell () _____ Email: _____

Age: _____ D.O.B: _____ Sexual Orientation: Male Female Unknown

Preferred pronouns: _____

Social Security #: _____ Place of Birth: _____

Cultural background: _____

Primary Language: _____

If other than English: Speaks English Understands English

Other languages spoken: _____

Background:

Education level: No school Elementary High School College Graduate School

Details of education level: _____

Occupation: _____

Were you in the military? Yes No

If yes, what branch? _____

What activities have you done in the past? ie: music, reading, sports, etc. _____

What activities do you enjoy now? _____

Marital Status:

Married Widowed Divorced Separated Never Married

Spouse Name (if applicable): _____

Living Arrangements:

Lives Alone Lives with someone: Name/Relationship: _____

How long at present address? _____

Prior residence: _____

Do you live in a house or apartment? _____

Do you have stairs? Yes No If yes, how many? _____

Do you have a ramp? Yes No

Family (indicate number of each):

Sisters: _____ Brothers: _____ Children: _____ Grandchildren: _____

List those whom you have regular contact/Whom would we call in a daytime emergency:

1. Name/Relationship: _____

Address: _____

Telephone: () _____ Work: () _____ Cell: _____

Email: _____

2. Name/Relationship: _____

Address: _____

Telephone: () _____ Work: () _____ Cell: _____

Email: _____

3. Name/Relationship: _____

Address: _____

Telephone: () _____ Work: () _____ Cell: _____

Email: _____

4. Name/Relationship: _____

Address: _____

Telephone: () _____ Work: () _____ Cell: _____

Email: _____

Financial Data & Services

1. Do you have?

Medicare#: _____

Part B: Yes No

Medicaid#: _____

Recertification Date: _____

Other Health Insurance: Yes No If yes, specify: _____

Do you belong to a Medicaid Managed Long Term Care? Yes No

If yes, specify: _____

2. Do you pay Medicaid Overage? Yes No

If yes, How Much? _____

To Whom? _____

How Often? _____

Who is responsible? _____

3. Monthly Income:

Source: _____

Amount: _____

4. Do you have Home Care? Home Health Aide Personal Care Aide

Agency Name: _____

Contact Person: _____ Phone: () _____

Days and Times of Service:

Sunday _____ Monday _____

Tuesday _____ Wednesday _____

Thursday _____ Friday _____

Saturday _____

Department of Social Services-Registered Nurse

Name: _____ Phone: _____

5. Do you receive Food Stamps? Yes No

6. Do you have any financial difficulty purchasing food? Yes No

7. Do you have a Personal Emergency Response System (Lifeline)? Yes No

8. Do you have Advanced Directives? Yes No

If yes:

Health Care Proxy Organ Donor

Living Will None Listed

DNR

9. Are you receiving assistance from any Mental Health, Social or Health Agency at this time?

Yes No

Name of Agency: _____

Phone: () _____

Case Manager: _____

Phone: () _____

Name of Psychiatrist: _____

Phone: () _____

10. Are there any issues you would like to discuss with our Social Worker? Please indicate: _____

Diagnosis/Major Health Concerns: _____

Recent Hospitalization or Surgery (past 5 years):

Hospital: _____ Date: _____ Reason: _____

Do you have a Pacemaker? Yes No Implanted Defibrillator? Yes No

If yes, who monitors the device and how often? _____

Primary Physician's Name: _____ Phone: _____

Address: _____

Specialists:

Name	Specialty	Phone	Address
------	-----------	-------	---------

_____	_____	_____	_____
-------	-------	-------	-------

Vaccine History (enter dates):

Tetanus: _____ Pneumovax: _____ Flu Vaccine: _____

PPD (Tuberculin Test): _____ Negative Positive _____ mm Chest X-ray: _____

Do you have any of the following?

Natural Teeth: Upper Lower None
Dentures: Upper Lower None

Difficulty chewing? Yes No Difficulty swallowing? Yes No

Any history of choking on food? Yes No If yes, special diet used _____

Any history of choking on liquid? Yes No If yes, are liquids modified _____

Any presence of Feeding Tube? Yes No If yes, what was prescribed by M.D. _____

5. List any nutritional supplements (Ensure, Glucerna, etc.) taken: _____

6. Describe your typical breakfast: _____

7. Describe your typical lunch: _____

8. Describe your typical dinner/supper: _____

9. Do you snack during the day? _____ Describe your typical snack: _____

10. Do you do your grocery shopping? _____ If not, who does it for you? _____
11. Do you do your own cooking? _____ If not, who does it for you? _____
12. Any constipation or diarrhea? Please specify: _____
13. Usual Body Weight? _____
14. Weight Loss or Weight Gain in the last 6 months? Please specify: _____

15. Difficulty tolerating certain foods (beans, milk, wheat)? _____

16. Are there any foods that you dislike? _____

Questionnaire completed by: _____
(please print)

Relationship to applicant: _____ Date: ____ / ____ / ____