

General Information Concerning Prospective Resident

Resident's Name _____ Age _____ Birth date ___/___/___

Home Address _____ Male Female

City _____ State _____ Zip _____

Telephone # _____ Name of Spouse _____

Resident's Social Security # _____ -- _____ -- _____ Religion _____

Resident is now at Home Hospital Nursing Home

Identify location if applicable: Name: _____

Telephone # _____ Date Admitted ___/___/___

Prospective Resident's Medical Insurance

Medicaid # _____ Medicare # _____

County _____ Case Worker _____

BC/BS # _____ Group # _____ Dental Insurance _____

Medication Insurance _____

If other insurance, please identify company and policy #'s

Company _____ Policy # _____ Group # _____

Is Resident or Spouse a veteran? Resident Spouse VA # _____

Please Furnish Copies of Medicare, Social Security, and other Insurance Cards

Resident's Personal Physician _____

Address _____ City _____ State _____ Zip _____

Telephone # _____ Will physician attend here? Yes No

Do you want to use local physician? Yes No

Marital Status

Choose one: Married Never Married Separated Divorced Widowed

Please identify people who are close to the resident:

e.g., spouse, children, other relatives, friends, etc. who can be contacted in case of emergency.

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone # (home) _____ (work) _____

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone # (home) _____ (work) _____

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone # (home) _____ (work) _____

Funeral Home Preference: _____

Address: _____ Phone # _____

Cemetery Preference: _____

Address: _____ Phone # _____

Medical Information Concerning Prospective Resident

Please check if you have any of the following advance directive for health care decisions and provide the Danforth with a copy of each document.

Terminal Care Document

Durable Power of Attorney for Health Care Decisions or Health Care Proxy

Representatives Name: _____

Code Status _____

Other _____

Applicant's Diagnosis _____

Medical Problems _____

Resident's last hospitalization: _____

Reason: _____ How Long? _____

Allergies: _____

Has Resident ever been in another Adult/Nursing Home? Yes No

If yes, when and where? _____

Why did the Resident leave Adult/Nursing home? _____

Any problems there? _____

Resident's Special Needs

Walks unassisted Uses wheelchair Uses walker Walks assisted

Grooming Yes No Special diet Yes No

Dressing Yes No Special skin care Yes No

Bathing Yes No Other _____

Is Resident incontinent? Yes No Bowel Bladder

Is Resident's eyesight? Good Poor

Does Resident wear glasses? Yes No

When was his/her last eye exam? ____/____/____

Does Resident wear hearing aid? Yes No Left Right Both

Does Resident wear dentures? Yes No

When was his/her last dental/gum exam? Yes No

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Date of last Tetanus: ____/____/____

Date of last Pneumovax: ____/____/____

Date of last Flu Shot: ____/____/____

Has applicant had a PPD Tine Test or Chest X-Ray in the last year? Yes No

If yes, when and where _____

Was the test or X-Ray positive for tuberculosis? _____

Has resident ever been exposed to tuberculosis? Yes No

If yes, when and where _____

Does the Resident usually desire to be dressed and groomed properly? Yes No

If no, please explain _____

Does the Resident generally get along well with others? Yes No

Does the Resident like to converse and socialize with others? Yes No

Does the Resident enjoy the opportunity for external activities? Yes No

Any other significant event or condition you remember about the Resident's status? _____

Financial and Legal Information

Resident's finances are managed by, Name: _____

(ATTACH A COPY OF DOCUMENT APPOINTING LEGAL REPRESENTATIVE)

Address _____

City _____ State _____ Zip _____

Phone # (home) _____ (work) _____

Legal Status Legal Guardian Power of Attorney Other _____

Person to Bill:

Name _____

Address _____ City _____ State _____ Zip _____

Assets:

Do you own a home? Yes No If yes, what is the assessed value \$ _____

Do you own other property? Yes No Type of property _____ value \$ _____

Do you have life insurance? Yes No Company _____

Face Value \$ _____ Cash Value \$ _____

Bank Account Information

Name(s) on Account	Bank Name/City	Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Do you own stocks or bonds? Yes No If yes, please complete the following:

Name of Stock/Bond	# of shares	Owned by	Value
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Income

Last Monthly Income for	Resident	Spouse	Total
Pension	\$ _____	\$ _____	\$ _____
Social Security	\$ _____	\$ _____	\$ _____
Retirement Income	\$ _____	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____	\$ _____
Other Income	\$ _____	\$ _____	\$ _____

Expenses

Medical Expenses	\$ _____	\$ _____	\$ _____
Dependent Expenses	\$ _____	\$ _____	\$ _____
Car Loan	\$ _____	\$ _____	\$ _____
Personal Loan	\$ _____	\$ _____	\$ _____
Mortgages	\$ _____	\$ _____	\$ _____
Other Expenses	\$ _____	\$ _____	\$ _____

I HEREBY GIVE PERMISSION TO THE DANFORTH ADULT CARE FACILITY TO VERIFY THE FINANCIAL INFORMATION SUPPLIED ON THIS APPLICATION AND FURTHER AGREE THAT THE FUNDS LISTED WILL BE FOR THE CARE OF THE APPLICANT DURING HIS/HER STAY AT THE DANFORTH ADULT CARE CENTER.

Resident's Signature

_____/_____/_____
Date

Signature of Financially Responsible Person

_____/_____/_____
Date