ADMISSION APPLICATION

DATE_____

UNIT APPLYING FOR ADMISSION TO: SKILLED CARE _____ MEMORY CARE _____
APPLICANT'S NAME _____
ADDRESS _____
PHONE NUMBER _____

MALE_____ **FEMALE**_____ **DATE OF BIRTH** _____
HEIGHT _____**WEIGHT**_____

PRIMARY PHYSICIAN_____**PHONE** _____
OTHER PHYSICIANS _____

MEDICARE #_____ **A / B / A&B**
SOCIAL SECURITY #_____**MEDICAID #**_____
INSURANCE NAME AND NUMBER _____
(ATTACH COPIES OF CARDS: FRONT & BACK)

DIAGNOSIS (MAIN HEALTH PROBLEMS) _____

_____

_____

_____

LIST OF MEDICATIONS _____

_____

_____

_____

_____

_____

_____

_____

_____

Oak Hill Financial Data

We are asking for the following information in order to assist us and you in ensuring that you receive financial assistance for services if you should qualify for such assistance. Therefore, it is imperative that you provide the most accurate information possible. We will use this information to help you apply for assistance in the future should your financial condition require it. We keep all financial information strictly confidential and only use this information to assist our facility in planning for its financial future and to ensure that you receive the benefits to which you are entitled.

Did you give/transfer any of your money/property such as land or buildings, stocks, bonds, or Certificates of Deposits to anyone within the last 60 months? ❑ YES ❑ NO

Did you sell any of your resources such as cars/property including stocks, bonds, or Certificate of Deposits to anyone within the last 60 months? ❑ YES ❑ NO

Did you give a loan, mortgage or make a promissory note with anyone within the last 60 months? ❑ YES ❑ NO

Assets

- Checking $_____ Bank Name: _____
- Savings $_____ Bank Name: _____
- Certificate of Deposit $_____
- Investments (Stocks/Bonds) $_____
- Funds in Trust $_____
- Life Insurance (Cash Value) $_____
- Other Assets $_____
- Home $_____
  Property Address: _____
- Rental Property $_____
  Property Address: _____

TOTAL ASSETS $_____

Liabilities

- Home Mortgage $_____
- Credit Cards $_____
- Supplemental Insurance Premium $_____
- Medicare B Premium $_____
- Medicare D Premium $_____
- Loans $_____
- Other (ie: spousal support) $_____

TOTAL LIABILITIES $_____

Monthly Income

- Social Security $_____
- Supplemental Security Income $_____
- Retirement or Pension $_____
- Annuities $_____
- VA Pension $_____
- Investment or Interest Income $_____
- Trust Income $_____
- Other (ie: spousal support) $_____

TOTAL MONTHLY INCOME $_____

EMERGENCY CONTACTS:

NAME_____RELATIONSHIP _____

ADDRESS AND ZIP _____

1ST PHONE NUMBER_____2ND PHONE NUMBER_____

E-MAIL _____

NAME_____RELATIONSHIP _____

ADDRESS AND ZIP _____

1ST PHONE NUMBER_____2ND PHONE NUMBER_____

E-MAIL _____

DOES THE APPLICANT HAVE PREPAID FUNERAL ARRANGEMENTS? ❑ YES ❑ NO

IF YES, WHERE?_____

DOES THE APPLICANT HAVE A LEGAL GUARDIAN? ❑ YES ❑ NO

DOES THE APPLICANT HAVE A HEALTH POWER OF ATTORNEY? ❑ YES ❑ NO

DOES THE APPLICANT HAVE A FINANCIAL POWER OF ATTORNEY? ❑ YES ❑ NO

DOES THE APPLICANT HAVE A LONG TERM CARE POLICY? ❑ YES ❑ NO

Daily Rate $_____

(ATTACH COPIES OF DOCUMENTS)

PLEASE INDICATE THE NEED FOR PLACEMENT (CHECK ONE)

❑ IMMEDIATE ❑ WILL CALL OAK HILL WHEN READY

APPLICANT IS NOW: ❑ LIVING ALONE

❑ LIVING WITH RELATIVES

Who? _____

❑ LIVING AT A NURSING HOME

Where? _____

❑ LIVING AT AN ASSISTED/INDEPENDENT LIVING

Where? _____

❑ AT HOSPITAL

Where? _____

CHECK THE SERVICES THE APPLICANT IS CURRENTLY RECEIVING:

❑ HOME HEALTH ❑ ADULT DAY CARE ❑ HOMEMAKERS ❑ MEALS-ON-WHEELS

PLEASE MARK ITEMS THAT DESCRIBE APPLICANT:

ACTIVITY:

- ❑ Walks independently
- ❑ Walks with walker
- ❑ Walks with cane
- ❑ Needs help to walk
- ❑ Uses wheelchair
- ❑ Needs help to get in/out of bed/chair
- ❑ Dresses self
- ❑ Needs help dressing
- ❑ Falls _____/per month

MENTAL STATUS:

- ❑ Alert
- ❑ Confused
- ❑ Forgetful

KIDNEY / BOWELS:

- ❑ Complete control
- ❑ May have accidents
- ❑ Usually incontinent
- ❑ Indwelling catheter
- ❑ Ostomy

EATING:

- ❑ Feeds self
- ❑ Needs help
- ❑ Tube feeding
- ❑ Special Diet

_____

SPECIAL MEDICAL CARE:

- ❑ Dialysis
- ❑ Chemotherapy
- ❑ Radiation
- ❑ Wounds
- ❑ Hospice
- ❑ Infections _____
- ❑ C Pap/Bipap
- ❑ Oxygen

PSYCHOSOCIAL:

- ❑ Social
- ❑ Withdrawn
- ❑ Physical Aggression
- ❑ Verbal Aggression
- ❑ Wanders outdoors
- ❑ Wanders indoors only
- ❑ Suicide attempts / thoughts
- ❑ Inappropriate Sexual Behaviors
- ❑ Tobacco Use
- ❑ Psychiatric Hospitalization
- ❑ Alcohol / Drug Abuse
  Amount Used _____
- ❑ Diagnosis of a major mental illness

  _____
- ❑ History of Felonies

ADDITIONAL INFORMATION _____

_____

_____

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_____

I hereby declare that the statements made herein are true and complete according to my best knowledge and belief.

Signature _____