

**Admission Application**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Maiden Name |  |
| Address |  | Phone |  |
| City |  | State |  | Zip |  |
| Date of Birth |  | Place of Birth |  |
| Religion |  | Church |  |
| Length of Residency in: | USA |  | Ohio |  | Citizen |  |
| Father’s Name |  | Mother’s Maiden Name |  |
| Marital Status: | Single |  | Married |  | Divorced |  | Separated |  | Widowed |  |
| Spouse Name |  | Date of Marriage |  | If Living, where |  |
| If Deceased, when |  | Cause of Death |  |
| Is applicant a current smoker? |  | We are a smoke free facility. |

Veteran? \_\_\_\_\_\_\_\_\_\_\_\_\_ Branch of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party and/or Family Contacts

|  |  |  |  |
| --- | --- | --- | --- |
| Responsible Party |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |
|  |
|  |
| Name |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |
|  |
|  |
| Name |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

|  |  |
| --- | --- |
| Attorney Name |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |
|  |
| Social Security Number |  |
|  |
| Medicare Number |  |
|  |
| Medicaid Number (Welfare) |  |
|  | Name/Phone Number of Caseworker: |  |
|  |  |
|  |  |

Who should receive the resident’s bills?

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

If the party listed above is not the resident, does this person have a durable power of attorney for the resident and is this person the resident’s responsible party? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Insurance Information

Is Medicare your Primary Insurance? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

If not, please list your **Primary** Medical Insurance:

|  |  |
| --- | --- |
| Name |  |
| Policy Number |  |

Please list any **Secondary** Medical Co-Insurance:

|  |  |
| --- | --- |
| Name |  |
| Policy Number |  |

Do you have an **HMO**? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name |  |
| Policy Number |  |

Prescription Plan (Medicare Part D or equivalent)

Does the Applicant receive **Supplemental** Security Income (SSI)?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes |  |  | No |  |  | Monthly Amount |  |

Please list hospitalizations (hospital and date) over the last two years:

|  |
| --- |
|  |
|  |
|  |

Have you ever applied/been admitted to/or denied admission by any other institution? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Home |  | Phone |  |
| Address |  |
| Reason for leaving |  |

Health Care Power of Attorney

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

**Do You Have a Living Will?** Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Financial Power of Attorney

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

Guardianship of Person:

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

Guardianship of Estate:

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |
| Address |  |
| City |  | State |  | Zip |  |
| Phone: | Home | ( ) |  | Work | ( ) |  |
|  | Cell | ( ) |  | E-Mail |  |

**Copies of these documents are to be submitted along with this application. These positions cannot be recognized without appropriate copies of these documents.**

Burial Arrangements:

|  |  |
| --- | --- |
| Undertaker |  |
| Address |  | Phone |  |
| Cemetery |  |
| Person responsible for burial arrangements: |  |
| Have arrangements been made? |  | Prepaid? |  |

**INFORMATIONAL DATA**

Health Insurance Company Policy Number

Medicare Provider Policy Number

Long-term Care Insurance Company

 Policy Number

 Amount of coverage per Day

Do you drive? Yes No Will you require Van transportation? Yes No

Car Insurance Company

 Policy Number

 License Plate Number Driver’s License Number

Physician Phone

Hospice Preference Phone

Dentist Phone

Pharmacy Phone

Mortuary Preference Phone

 Address Phone

**IN CASE OF EMERGENCY CONTACT:**

1. Name Relationship

 Home Phone Business Phone

 Address City State Zip

1. Name Relationship

 Home Phone Business Phone

 Address City State Zip

HEALTH HISTORY

(To be completed by applicant)

**Your complete medical history and physical examination results will be recorded on another form completed by your physician. The form must be submitted prior to occupancy at The Villas.**

1. List pertinent **past** medical history with dates. Include serious injuries, illnesses and operations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List **current** medical history and recent hospitalizations with dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List **current** medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have: Do you use:

\_\_\_\_ Palpitations \_\_\_\_ Hearing Aids \_\_\_\_ Right \_\_\_\_ Left

\_\_\_\_ High Blood Pressure \_\_\_\_ Dentures \_\_\_\_ Upper \_\_\_\_ Lower

\_\_\_\_ Diabetes \_\_\_\_ Glasses

\_\_\_\_ Urinary Problems \_\_\_\_ Walker

\_\_\_\_ Headaches \_\_\_\_ Wheel Chair

\_\_\_\_ Dizziness \_\_\_\_ Electric Cart

\_\_\_\_ Pacemaker

1. Do you have a special diet? \_\_\_\_ Yes \_\_\_\_ No If so, what is your diet? \_\_\_\_\_\_\_\_\_\_\_
2. How many meals do you eat per day? \_\_\_\_\_\_\_\_\_\_\_
3. List any allergies to food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have any history of emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you smoke tobacco? \_\_\_\_ Yes \_\_\_\_ No
6. How often do you drink alcohol each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Check the type of daily assistance you need:

\_\_\_\_ Dressing \_\_\_\_ Bathing \_\_\_\_ Eating \_\_\_\_ Ambulation

**FINANCIAL DISCLOSURE**

This Financial Disclosure form is used to help assess your financial resources to pay for skilled nursing care. After completing this form, a mutual understanding of your financial obligations will be established.

We require this information of our Residents regardless of their method of payment. Completing this form before admission day will assist us in helping you make the best decisions and will expedite the admission process. All information will be kept confidential and if you choose our facility, this form will become part of your admission agreement

General Information:

|  |  |
| --- | --- |
| Prospective Resident’s Name |  |
| If you are not the prospective Resident: |
|  | Your name |  | Relationship |  |
| Prospective Resident’s Spouse |  |

Legal Representatives:

Please provide agreements designating each legal representative. (Example: Legal Guardian, POA, DPOA, Guarantor, Responsible Party)

|  |  |
| --- | --- |
| Type of legal representative: |  |
| Name |  | Phone |  |
| Address |  |
| Title or relationship to Resident |  |
| Type of legal representative: |  |
| Name |  | Phone |  |
| Address |  |
| Title or relationship to Resident |  |

Financial Information:

**Monthly Income:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Salary | $ |  |  | Social Security | $ |  |
| Pension | $ |  |  | IRA | $ |  |
| Annuity | $ |  |  | Disability Income | $ |  |
| Rental Income | $ |  |  | Other | $ |  |
| Total Income (all sources): | $ |  |  |

**Cash Assets:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bank #l |  |  | Location |  |
| Checking Account # |  |  | Balance in Account: | $ |  |
| Savings Account # |  |  | Balance in Account: | $ |  |
| Certificates of Deposit? | Yes |  | No |  |  | If yes, approximate amount | $ |  |
|  |  |  |  |  |
| Bank #2 |  |  | Location |  |
| Checking Account # |  |  | Balance in Account: | $ |  |
| Savings-Account # |  |  | Balance in Account: | $ |  |
| Certificates of Deposit? | Yes |  | No |  |  | If yes, approximate amount | $ |  |

(If there are additional cash assets which require additional space, please list the location of these assets and the amount on a separate sheet and attach to this financial disclosure.

|  |  |  |
| --- | --- | --- |
| **Total of all cash assets listed:** | $ |  |

**Real Estate Assets:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Does the Resident own a home? | Yes |  | No |  |  | If yes, approximate value $ |  |
| Does the Resident own any other  | Yes |  | No |  |  | If yes, approximate value $ |  |
| property? |  |  |  |  |  | If yes, what and where is property located? |
|  |  |  |  |  |
| **Total value of all properties owned:** | $ |  |  |  |

Life Insurance Cash Value:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the Resident have life insurance policies with cash value? | Yes |  |  | No |  |
|  |
| Company Name |  | Approximate cash value $ |  |
| Agent Name |  | Phone |  |
| Annuities $ |  |  |  |

(If life insurance is held by more than one agent, please list agents and the amount they handle on a separate sheet-and attached to this financial disclosure).

|  |  |  |
| --- | --- | --- |
| **Total of all cash values listed**: | $ |  |

**Securities**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Does the Resident have stocks and bonds? | Yes |  |  | No |  |  |
| Approximate current market value of all securities: $ |  |  |
|  |  |  |  |  |
| Agent handling securities: | Name |  | Phone |  |
|  | Address |  |

(If more than one agent holds securities, please list these agents and the amount they handle on a separate sheet and attached to this financial disclosure).

**Assets Transferred to or Held in Trust:**

|  |  |  |
| --- | --- | --- |
|  | Identify assets held in Trust |  |
|  | On what date were assets transferred to Trust? |  |
|  | Approximate value of assets held in Trust |  |
|  | (Copy of Trust Agreement required) |  |

**Other:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any other sources of income that have not been identified above? | Yes |  |  | No |  |
|  | Please identify the source(s): |  |
|  | Approximate current market value of these sources: | $ |  |
| From what source(s) does the Resident plan to pay for services at the Facility? |
|  |
|  |

If necessary, would the Resident be willing to liquidate his/her assets to pay for services at the Facility? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If the Resident’s resources become insufficient to meet total expenses while residing at the Facility are there other persons or organizations that could help pay for services? If yes, please specify:

|  |
| --- |
|  |
|  |

Are there any safeguards to ensure that your resources are used only for the Resident’s benefit? If yes, please specify:

|  |
| --- |
|  |
|  |

During the past five years, has the Resident given or transferred any cash, property or other assets (valued at more than $1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

|  |
| --- |
|  |
|  |
|  |

Who will handle the Resident’s financial affairs while he/she is a Resident at the Facility?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name |  | Relationship |  |
|  | Address |  | Legal Relationship |  |
|  | Phone |  |  |  |
|  |  |  |  |  |
| In the past seven years has the Resident declared bankruptcy or had judgments against them? |
|  | Yes |  |  | No |  |  |
|  |
| If yes, please specify: |
|  |
|  |
|  |

**Liabilities:**

Please list any balance owed by the Resident on the following items:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | House Loans | $ |  |  | Medical Expenses: |  |  |
|  | Credit Cards | $ |  |  | Doctor | $ |  |  |
|  | Automobiles | $ |  |  | Prescriptions | $ |  |  |
|  | Notes | $ |  |  | Hospital | $ |  |  |
| **Total Liabilities:** | $ |  |  |  |  | (C) $ |  |
| **Estimate of residual assets:** |
|  | Monthly Income | $ |  |  |  | (A) $ |  |
|  | Total Assets | $ |  |  |  | (B) $ |  |
|  | -Total Liabilities | $ |  |  |  | (C) $ |  |
|  | Residual Assets | $ |  |  |  |  |  |

Authorization:

I hereby state that to the best of knowledge the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging Resident from Facility. I authorize Facility to investigate financial and credit records through any investigative or credit agency(s) of its choice.

|  |  |  |  |
| --- | --- | --- | --- |
| Resident |  | Date |  |
| Legal Representative: |  | Date |  |
|  | Legal Guardian, POA, DPOA |  |
| Responsible Party/Agent: |  |  |
| Date |  |  |  |
| Facility Representative |  | Date |  |
| Witness\* |  | Date |  |
| Witness\* |  | Date |  |

**\*Required only if Resident is unable to sign his/her name**

This Application Completed By:

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of Application |  |
|  |
| Referred by |  |
|  |
|  |
| **Signature of Prospective Resident** |  |
|  |  |
|  |  |

**Representation of Resident:**

**The Resident represents that the information contained on the Application Forms, financial disclosure and health history, which are attached hereto and incorporated in this agreement by reference, are true to the best of his/her knowledge and belief. Resident understands that the Facility has relied upon such information and agrees that any misrepresentation or material omission made by a Resident in connection therewith shall render this agreement void at the option of the Facility.**

Ohio State & Federal laws prohibit discrimination based on race, creed,
color, national origin, sex, sponsor, disability or age.