Nursing Care Admission Application

Complete the Application in full, as background information is helpful to staff at the time of admission.

Section 1 ~ Personal/Contact Information (Please print or type)

Name: _____
First Middle Last

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip:** _____

SS#: _____ **Age:** _____ **DOB:** _____

Birthplace: _____ **Marital Status:** _____

Spouse's Name: _____

Children/Relatives/Friends to contact in case of an Emergency

Name: _____ Relationship: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Evening #:** _____ **Cell #:** _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Evening #: _____ Cell #: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Evening #: _____ Cell #: _____

Power of Attorney

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Evening #: _____ Cell #: _____

Section 1 ~ Personal/Contact Information (Continued) (Please print or type)

Education

Highest Grade Completed: _____ Name of School: _____

Occupation & Employment

Lifetime Occupation: _____ Other Employment: _____

Military Background

Branch: _____ Years of Service: _____

Religion

Church/Synagogue: _____

Contact Person: _____

Activities Involved in: _____

Organizations involved in (Interests/Hobbies - include both past & present):

_____

_____

Section 2 ~ Medical Information (Please print or type)

Medical Examination

When accepted as a Resident, I agree to undergo a medical examination based on the form required by The Sarah A. Reed Retirement Center. I understand that admission as a Resident is subject to the results of this examination together with any other or more detailed supplementary information required by the Medical Team.

Physician/s: _____

Living Will: Yes ____ No ____ **Hospital Preference:** _____

Glasses: Yes ____ No ____

Dentures: Yes ____ No ____ **Emergycare Member:** Yes ____ No ____

Hearing Aid: Yes ____ No ____ **Lift Member:** Yes ____ No ____

Insurance Coverage

Medicare Number: _____

Medicare Prescription Drug Plan: _____

Medicaid Number: _____

PACE Card: Yes ____ No ____ **HMO:** Yes ____ No ____

HMO Name: _____

Supplemental Insurance Agreement Number: _____

Supplemental Insurance Group Number: _____

Section 3 ~ Financial Information (Please print or type)

Current Monthly Income

	Self		Spouse	
Social Security (net)	_____	/Month	_____	/Month
Pension	_____	/Month	_____	/Month
Salary or Wages	_____	/Month	_____	/Month
Guaranteed Annuities	_____	/Month	_____	/Month
Other Interest Income	_____	/Month	_____	/Month

Bank Accounts

Financial Institute	Type of Account	Balance	Self/Spouse/Joint

Stocks and Bonds

Types of Security	Market Value	Self/Spouse/Joint

Real Estate (Owned/Mortgaged - Circle One)

Location	Value	Self/Spouse/Joint

Life Insurance

Location	Value	Self/Spouse/Joint

Section 4 ~ Additional Information (Please print or type)

Debts & Obligations

Balance	Self/Spouse/Joint

Assets disposed of in the last 3-5 years

Funeral Home

Pre-paid Funeral Arrangements: Yes ____ No ____

Funeral Home Director: _____

Address: _____

Phone Number: _____

Date of Desired Entrance: ____/____/____

Accommodation Desired: _____

Additional Remarks: _____

WAIVER OF RIGHTS OF PRIVACY

I understand that with the processing of this application, it is necessary that information presented herein be made known to and verified by The Sarah A. Reed Retirement Center. Inquiries are hereby authorized and all rights of privacy herein are hereby waived by me for this purpose.

CERTIFICATION OF TRUTHFULNESS

According to the best of my knowledge, the information provided in this application is complete, accurate and true.

_____ ____/____/____

Signature of Applicant or Responsible Party Date