Personal Care or Health Care Inquiry for Admission

Date of Application___________________

Name ____ Date of Birth ________________ Social Security #_______________________

Address____City___________________________ State/Zip Code________________

How long have you resided at current address?_________ Birthplace:_______________________ Home Telephone Number ______________________

Are you: □ Married □ Single □ Separated □ Divorced □ Widowed Are you a veteran? □ Yes or □ No Which branch and years served____________

First Person Contact Information

Name____________________________ Address_____________________________________ Telephone #________________Relationship_____________

Second Person Contact Information

Name____________________________ Address______________________________________ Telephone #________________Relationship_____________

Name(s) of children/responsible party Address Telephone #: Email:

______________________________ ____ _____________________ ________________________

______________________________ ____ _____________________ ________________________

______________________________ ____ _____________________ ________________________

Religion______________ Church___________________________ Address__________________________________ Telephone___________________

Current Physician_____________________________ Preferred Hospital______________________________________

Were you hospitalized within the last 60 days? □ Yes or □ No If yes, please provide dates, where you were hospitalized and reason for hospitalization.

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Funeral Director Name__________________________ Address____ Telephone____________________

Activities of Daily Living

Ambulation: □ Independent □ Assisted □ Use Assistive Device □ Non-Ambulatory

Vision: □ Good □ Fair □ Glasses □ Blind (Right-Left)

Eating Habits: □ Independent □ Needs Assistance □ Unable □ Feeding Tube

Bathing/Dressing: □ Independent □ Needs Assistance □ Unable

Mental Status: □ Alert & Oriented □ Forgetful □ Confused

Hearing: □ Normal □ Impaired □ Hearing Aid □ Deaf (Right-Left)

Speech: □ Normal □ Impaired □ Aphasic

Continence *Bowel*: □ Continent □ Incontinent □ Unable
Continence *Bladder*: □ Continent □ Incontinent □ Cathedar

Diagnosis and Explanation of Care Needs

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Is applicant presently residing in a nursing home? □ Yes or □ No If yes, give name of nursing home__________________________________

address________________________________reason for placement____

Reason for this application____

Power of Attorney for Health Care and/or Financial

Name(s) of POA, Guardian/Conservator	Address	Telephone number:	Email:
____________________	____________________________	________________	________________
____________________	____________________________	________________	________________

Health Insurance: List agreement/policy number and type of plan.

Medicare______________________ Security Blue________________________ Blue Cross/Blue Shield___________________

UMWA_______________________ Medical Assistance____________________ Other______________________________

Prescription Card____________________________________

PLEASE PROVIDE A COPY OF MEDICARE CARDS WITH THIS FORM

Financial Information

Person responsible for finances ____

Current Monthly Income	Amount
Social Security	
SSI	
United Mine Workers	
Black Lung	
Veteran Benefits	
Railroad Retirement	
Retired Teacher	
Other	

Savings Account Bank Name	Account Balance	Bank Address	Account Number	Names on Account
Checking Accounts Bank Name	Account Balance	Bank Address	Account Number	Names on the Account
Real Estate	Value	Address	Name on Deed	Does Spouse or child reside there?
Life Insurance Company Name	Value	Company Address	Policy Number	
Burial Fund Bank/Funeral Home Name	Value	Address		
Stocks, Bonds, CDS, Investments	Value			

By signing this form, I acknowledge that all of the above information is true and correct to the best of my knowledge and is available for my or the applicant's care to the extent that the law allows.

Signature_______________________________________ **Relationship to applicant**____________________________ **Date**____________________