



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.

Funeral Director Name _____ Address _____ Telephone _____

Activities of Daily Living

Ambulation: Independent Assisted Use Assistive Device Non-Ambulatory

Mental Status: Alert & Oriented Forgetful Confused

Vision: Good Fair Glasses Blind (Right-Left)

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

Eating Habits: Independent Needs Assistance Unable Feeding Tube

Speech: Normal Impaired Aphasic

Bathing/Dressing: Independent Needs Assistance Unable

Continenence *Bowel*: Continent Incontinent Unable

Continenence *Bladder*: Continent Incontinent Cathedar

Diagnosis and Explanation of Care Needs

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** _____