



ADMISSION APPLICATION

DATE _____

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 _____

Magnolia Terrace 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 _____

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

Signature _____