



ADMISSIONS APPLICATION

MARKESAN RESIDENT HOME: North Terrace, Skilled Nursing and Anna's House

Please answer all questions as accurately and completely as possible. The information you provide is for staff use only. It will be held in the strictest confidence.

Date: _____

Personal Information

Name: _____
(Last) (First) (MI) (Maiden)

Home Address: _____
(Street) (City) (State/Zip)

County: _____ Phone Number: _____

Names of those living with the applicant (relationship): _____

Where did the applicant live most of his/her adult life: _____

Presently at: Home: _____ Other living arrangement: _____
Hospital (name): _____
Since when? _____

Has the applicant ever lived in any retirement community, nursing home or swing bed? _____
If yes, where and when? _____

Date of birth: _____ Sex: male female Age: _____

Place of birth: _____ Marital Status: S M W D

Marriage date: _____ Name of spouse: _____

Address of Spouse, if living: _____
(if deceased - date of death)

Religion/Church Affiliation: _____ Pastor: _____
Address: _____ Phone: _____

Funeral Home: _____ Phone: _____
Address: _____

Do you have a burial trust established? _____

Notify in Case of Emergency - Please list three contacts in order of priority

1. Name: _____ Relationship: _____
Address: _____
Phone (Home): _____ (Work): _____
Email Address: _____

2. Name: _____ Relationship: _____
Address: _____
Phone (Home): _____ (Work): _____
Email Address: _____

3. Name: _____ Relationship: _____
Address: _____
Phone (Home): _____ (Work): _____
Email Address: _____

Other Family Information

Father's Name: _____ Mother's Name (Maiden): _____
Birthplace: _____ Birthplace: _____
Age (or date of death): _____
Age (or date of death): _____
Cause of death: _____ Cause of death: _____

Brothers and Sisters (Please note whether living or deceased and provide address if living):

1. _____
2. _____
3. _____
4. _____
5. _____

Children (Please note whether living or deceased and provide address and phone number):

1. _____
2. _____
3. _____
4. _____
5. _____

Significant Others (Name, address, phone number, relationship/agency):

1. _____
2. _____

Former Occupations: _____

Date retired: _____ Education (grade completed): _____

Lodges, Clubs, Veteran's Organizations and Community Activities: _____

Military Service: _____

Activities and Hobbies that the applicant is or was interested in:

- | | | | |
|----------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> sports | <input type="checkbox"/> gardening | <input type="checkbox"/> pets | <input type="checkbox"/> reading |
| <input type="checkbox"/> sewing | <input type="checkbox"/> cards/games | <input type="checkbox"/> crafts | <input type="checkbox"/> handiwork |
| <input type="checkbox"/> radio | <input type="checkbox"/> TV/movies | <input type="checkbox"/> music | <input type="checkbox"/> woodworking |
| <input type="checkbox"/> walking | <input type="checkbox"/> fishing | <input type="checkbox"/> auto rides | |

Health Information

Primary physician: _____

Date last seen: _____

Other physicians or specialist: _____

Date last seen: _____

Dentist: _____

Date last seen: _____

Advanced Directives - Please circle any of the following that have been executed:

- | | |
|--|---------------------------------|
| 1. Living Will | 6. Medication Restrictions |
| 2. Power of Attorney for Healthcare | 7. Other Treatment Restrictions |
| 3. Do not Resuscitate (No Code) | 8. Organ Donations |
| 4. Do not Hospitalize | 9. Autopsy Requests |
| 5. Feeding Restrictions | |

Note: If there is pertinent health information that would be helpful for us to have in order to better provide care for the applicant, please include that information on a separate sheet.

Does the applicant have a legal...

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| 1. Financial Power of Attorney | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 2. Durable Power of Attorney | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 3. Guardian | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Name: _____ Phone: _____

Address: _____

Note: Documentation verifying the above will be necessary at the time of admission.

Financial Information

Private Pay: _____ Medical Assistance: _____ SSI: _____

Medicare: _____

Medicaid: _____

Social Security Number: _____

Other Health Insurance: _____

Note: Please provide copies of insurance cards (or copies can be made for you).

Monthly income: (Social Security, SSI, Veterans Benefits, Pensions, Interest, Dividends, Annuities, Rent, Other)

Source:	Amount:
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
Total	\$ _____

Assets: (Checking, Savings, CD's, Stocks, Bonds, Other)

Source:	Amount:
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
Total	\$ _____

Has there been a divestment in the past 60 months? yes no

Federal Law, entitled **The Spousal Impoverishment Act**, provides some financial protection to a nursing home resident's spouse who remains in the community. If you need information on taking advantage of this Act, our Social Worker/Admissions Coordinator will be happy to provide information to you.

To whom should the bill be sent?

Name: _____ Phone: _____

Address: _____

I hereby give consent of release of the Applicant's Medical information as needed for admission purposes. I have correctly answered all questions to the best of my knowledge.

Applicant: _____ Date: _____

Date: _____

Authorized Signature

Markesan Resident Home does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Veteran Status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.