



# 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 #: \_\_\_\_\_

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Evening #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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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**

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

**Bank Accounts**

<b>Financial Institute</b>	<b>Type of Account</b>	<b>Balance</b>	<b>Self/Spouse/Joint</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Stocks and Bonds**

<b>Types of Security</b>	<b>Market Value</b>	<b>Self/Spouse/Joint</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Real Estate (Owned/Mortgaged - Circle One)**

<b>Location</b>	<b>Value</b>	<b>Self/Spouse/Joint</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Life Insurance**

<b>Location</b>	<b>Value</b>	<b>Self/Spouse/Joint</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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:** \_\_\_\_\_

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**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