APPLICATION FOR ADMISSION

I.

NAME OF APPLICANT:_____
Last First Middle

AGE_____ BIRTHDATE_____ MALE:____ FEMALE:____ MARITAL STATUS:_____

LAST ADDRESS:_____

BIRTHPLACE:_____ SPOUSE NAME:_____RELIGION: _____

RESIDENT'S PREVIOUS OCCUPATION:_____SOC. SEC #: _____

MILITARY SERVICE-BRANCH-DATE:_____ MEDICARE #: _____

FATHER'S NAME_____ MOTHER'S MAIDEN NAME_____

PUBLIC AID RECIPIENTS ONLY: MEDICAID # _____ RECIPIENT #_____

PERSON TO CONTACT IN CASE OF EMERGENCY:
1ST PERSON

NAME_____ RELATIONSHIP_____ HOME PHONE:_____

ADDRESS_____ CITY_____ ZIP_____

EMPLOYER_____ CITY_____ WORK PHONE:_____

E-MAIL ADDRESS:_____CELL PHONE: _____

2ND PERSON

NAME_____ RELATIONSHIP_____ HOME PHONE:_____

ADDRESS_____ CITY_____ ZIP_____

EMPLOYER_____ CITY_____ WORK PHONE:_____

3RD PERSON

NAME_____ RELATIONSHIP_____ HOME PHONE:_____

ADDRESS_____ CITY_____ ZIP_____

EMPLOYER_____ CITY_____ WORK PHONE:_____

II. ELIGIBILITY:

IS APPLICANT A RESIDENT OF PIATT COUNTY? YES ____ NO ____ HOW LONG _____ Yrs.

IS APPLICANT A LAND/HOME OWNER OF PIATT COUNTY YES ___ NO ____ HOW LONG _

IS APPLICANT A RELATIVE OF A PIATT COUNTY RESIDENT? YES ____ NO _____

NAME OF RELATIVE:_____ RELATIONSHIP TO APPLICANT:_____

ADDRESS:_____ PHONE:_____

WHERE IS APPLICANT RESIDING NOW? _____

III. **MEDICAL HISTORY**

NAME OF PHYSICIAN:_____

DOES APPLICANT HAVE: A HISTORY OF:

MENTAL ILLNESS? YES _____ NO _____

DEVELOPMENTAL DISABILITY? YES _____ NO_____

Advanced Directives: (Check those items which the applicant has)
Power of Attorney - Healthcare _____ Power of Attorney - Property _____
Living Will ____ Feeding Restrictions_____

Do Not Resuscitate _____ Organ Donation_____

Funeral Home: _____ Phone Number:_____

IV. FINANCIAL DATA:

Financial Responsibility By: Patient _____ Guardian _____ Power of Attorney _____

Public Aid _____ Family _____

Other (Explain) _____
IS APPLICANT RECEIVING PUBLIC AID ASSISTANCE? YES _____ NO _____

If 60 day finances are not available, (approximately $6,500) have you made contact with the Healthcare and Family Services? YES ____ NO ____ WHEN _

INSURANCE

A. Life Insurance (Value)
Company

_____ $ _____

_____ $ _____

B. Medical Insurance Premium: $ _____
Company _____

Medicare Part D Premium $ _____
Company _____

C. Long-Term Care (Supportive Living) Insurance
Company _____
1) Is a hospital stay required? _____
2) Daily benefit payment $_____
3) Coverage period (circle)
1 yr. 2 yrs. 3 yrs. Other_____

MONTHLY INCOME

INCOME

A. Social Security - Applicant $_____
Social Security - Spouse $_____

B. Pensions (List Source)

_____ $_____

_____ $_____

C. Annuities, Etc. Monthly Income

_____ $_____

D. Other Income (Describe)

_____ $_____

TOTAL MONTHLY INCOME $_____

ASSETS

A. Cash/Savings/CD's (Bank) (Value)

_____ $_____

_____ $_____

_____ $_____

B. Total Liquid Assets (Stocks, Bonds, etc.) (Value)

_____ $_____

C. Total Capital Assets (House, Real Estate, Car) (Value)

_____ $_____

TOTAL ASSETS $_____

V. LIABILITIES

Mortgage_____ $_____

Installment Payments $_____

Other (Describe)_____ $ _____

TOTAL LIABILITIES $ _____

Is applicant physically and mentally able to understand and sign a contract with Piatt County Nursing Home for his/her
care? _____

I hereby authorize Piatt County Nursing Home to contact my physician or other healthcare entities to obtain past medical information and hereby release all persons from any liability due to furnishing such information.

I (we) certify and attest that the information provided, pages 1 thru 5 of this Application For Admission, is complete and correct. I (we) agree and understand that any material misstatement or omission may, at Piatt County Nursing Home's option, render any contract subsequently entered into between Piatt County Nursing Home and resident(s) null and void.

SIGNED BY: _____

NAME RELATIONSHIP

_____

ADDRESS

_____

HOME PHONE WORK PHONE

RECEIVED BY: _____ DATE RECEIVED: _____

OFFICE USE ONLY

_____ PLACED ON WAITING LIST _____ APPROVED _____

DATE

_____ DENIED ADMISSION REASON _____

COMMENTS: _____

_____

_____