



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 # _____

SPOUSE MILITARY _____

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)

\$

D. Has the applicant established a financial trust for the purpose of estate planning?

Yes: _____ No: _____

If yes please explain: _____

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: _____

