

Personal/Financial Information

Primary Contact

Name _____ Relationship _____

Address _____ Home Phone _____

Town _____ State _____ Work Phone _____

Secondary Contact

Name _____ Relationship _____

Address _____ Home Phone _____

Town _____ State _____ Work Phone _____

Veteran Yes No U.S. Citizen Yes No

Financial Disclosure: (All information supplied will remain confidential. Application cannot be processed without this information.)

Social Security Number _____ Medicare Number _____

Medicaid Number (Title 19) _____ Pending? Yes No

Medicaid Caseworker's Name _____ Phone _____

Managed Medicare, Commercial, Medicare Supplement _____ Policy No. _____

Does Applicant Own a Long Term Care Insurance Policy? _____

Name of Company _____ Is this a Partnership Approved Policy? _____

Established Monthly Income: Social Security _____ Other _____

Assets: negotiable securities, stocks, bonds _____

Savings/Checking Accounts:

Bank	Type of Account	Joint/Single	Balance

Properties: _____ Names on Deed: _____

Mortgage notes you hold on properties _____

Has there been a transfer of assets or monetary gifts within the last 60 months? Yes No

Be specific _____

Name _____ Phone No. (home) _____

Address _____ Town _____ Phone No. (work) _____

Relationship _____

Signature of person completing application _____

Admission Application



You have contacted this facility and indicated a desire to be considered for admission. Your name will be placed on our waiting list after you substantially complete and return this application.

SMOKE FREE ENVIRONMENT

Jerome Home Application for Admission

Vital Statistics

Name _____ Telephone _____

Address _____ Town _____ State _____ Zip Code _____

Date of Birth _____ Birthplace _____

Marital Status _____ Religion _____

Occupation (Current or Former) _____

Type of Placement Being Sought (*Please Check*):

Short Term Rehab Hospice Care Respite Care Long Term Care

Medical Information

Present Location _____

If Hospital/Health Facility, Date of Admission _____

Admitting Diagnosis _____

Surgery (include dates) _____

Past Medical History _____

Allergies _____

Current Medications _____

Skin Condition

Surgical Site _____ Reddened Areas _____

Decubitus _____ Treatment _____

Diet _____ HT _____ WT _____

Mental Status

Alert Oriented Confused Disoriented Forgetful

Vague Non-responsive Depressed

Behavior Patterns

Cooperative Wanders Paces Combative Verbally Abusive

Resistive to Care Easily Agitated Other _____

Restraints Waist Vest Pelvic

Restraints Always Daytime Nighttime As Needed None

Current Therapies PT OT Speech
 Other _____

Functional Data Summary

	Independent	Minimal Assist (Supervise)	Maximum Assist (1-2 Person)	Unable	Independent
Bathing					
Dressing					
Toileting					
Eating					<input type="checkbox"/> G Tube <input type="checkbox"/> NG Tube
Transferring					<input type="checkbox"/> Hoyer Lift
Ambulating					

Continence

Continent Incontinent
If Incontinent: Urine Stool

Foley Catheter Suprapubic Catheter Texas Catheter (External Device)

St. Catheter Colostomy Ileo Conduit

Mechanical Aids

Oxygen/Liters _____

Pace Maker Yes No Date Inserted _____

Prosthesis (Type): _____

History of Psychiatric Problems or Disorders (Include Details and Dates of Hospitalization)

History of Alcohol or Substance Use? If Yes, Describe

Smoker Yes No

Miscellaneous Information

Primary Care Physician _____

Other Physician(s) _____

Advance Directives Yes No

If Yes, Please indicate: POA DPOA HCA Living Will Organ Donor Conservator

During the last 60 days, has there been a stay in a hospital or nursing facility? _____ If so, please indicate where and when stay took place. _____

Have Home Care Services been used in the past? _____

If so, please indicate which agency. _____

Funeral Home Preference: _____

Have arrangements been made? _____ Prepaid? _____