



ASSISTED LIVING

NURSING AND REHABILITATION CENTER

3210 Powder Mill Road Adelphi, Maryland 20783
Telephone: (301) 937-3939 www.Hillhaven.com
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APPLICATION FOR ADMISSION

GENERAL INFORMATION

Applicant's Name _____
(Last) (First) (Middle)

Spouse's Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (County) (State) (Zip Code)

Telephone No. _____ Age _____ Date of Birth _____
(Area Code)

Sex M F Marital Status S W D M Social Security # _____

Medicare # _____ Part A Part B Medicaid # _____

Private Insurance _____
(Company) (ID Number) (Group Number)

Date of Expected Move-In _____

If applicant is not at their own home, please specify their current living arrangements:

Name _____ (Phone Number) _____

Address _____
(Street) (City) (State) (Zip Code)

Has the applicant been admitted to a Skilled Nursing Facility within the past year? Yes No

If yes, Name _____ (Phone Number) _____

Address _____
(Street) (City) (State) (Zip Code)

Dates of Admission and Discharges: _____

Referral Source: Friend Relative Walk-In Government Agency Private Agency
 Physician Hospital Other Advertisement Web Site

Please List the Name of Source _____

Who Will Be Making the Placement Decision?

Name: _____ Relationship _____

Telephone No. (H) _____ (W) _____
(Area Code) (Area Code)

CURRENT MEDICAL INFORMATION

Please list the Resident's personal physician: Name: _____

Address _____
(Street) (City) (State) (Zip Code) (Phone Number)

Medical Condition (Diagnosis): _____

Please list medications that the Resident is currently taking: _____

Please list prior hospitalizations (Date / Hospital / Reason): _____

Please list any known allergies: _____

Is the admission expected to be temporary? Yes No If yes, what are the plans for discharge? _____

Special Care Assessment - Check yes or no in all that apply.

Does the Resident:	Yes	No		Yes	No
Walk unassisted	<input type="checkbox"/>	<input type="checkbox"/>	Need assistance in grooming	<input type="checkbox"/>	<input type="checkbox"/>
Use a walker / cane	<input type="checkbox"/>	<input type="checkbox"/>	Need assistance in bathing	<input type="checkbox"/>	<input type="checkbox"/>
Walks with assistance	<input type="checkbox"/>	<input type="checkbox"/>	Wear dentures	<input type="checkbox"/>	<input type="checkbox"/>
Uses a wheel chair	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
Require 24 hr bed care	<input type="checkbox"/>	<input type="checkbox"/>	Require tube feeding	<input type="checkbox"/>	<input type="checkbox"/>
Require oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Need incontinence care of bladder	<input type="checkbox"/>	<input type="checkbox"/>
Require wound/skin care	<input type="checkbox"/>	<input type="checkbox"/>	Need incontinence care of bowels	<input type="checkbox"/>	<input type="checkbox"/>
Require catheter care	<input type="checkbox"/>	<input type="checkbox"/>	Use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>

Resident's current height _____ and weight _____.

Does the Resident have any special dietary needs? Explain: _____

Does the Resident require any other special care needs? Explain: _____

Social and Mental Status Assessment - Check yes or no to all that apply.

Does the Resident...	Yes	No		Yes	No
Desire to be dressed and groomed properly	<input type="checkbox"/>	<input type="checkbox"/>	Tend to be quiet and reserved	<input type="checkbox"/>	<input type="checkbox"/>
Have a history of combative/abusive behavior	<input type="checkbox"/>	<input type="checkbox"/>	Like to socialize with others	<input type="checkbox"/>	<input type="checkbox"/>
Usually get along with others	<input type="checkbox"/>	<input type="checkbox"/>	Scream or yells out	<input type="checkbox"/>	<input type="checkbox"/>
Tend to be depressed or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of mental illness	<input type="checkbox"/>	<input type="checkbox"/>

Describe the Resident's general personality/disposition. (For example: does the Resident know person, place and time, long and short term memory, emotional state, anxiety level, social status and communication level) _____

Describe in your own words what has brought the resident to this facility? _____

Describe the typical day for the applicant? _____

Will the resident be driving an automobile? Yes No If yes, provide a copy of your current valid Drivers License and describe your automobile (color, make, model License Plate Number)? _____

AGENT INFORMATION

Power of Attorney (Financial) or person responsible for payment of bills (Agent)

Name: _____ Relationship _____

Address _____

(Street) (City) (State) (Zip Code)

Telephone No. (H) _____ (W) _____
(Area Code) (Area Code)

Durable (Medical) Power of Attorney

Name: _____ Relationship _____

Address _____

(Street) (City) (State) (Zip Code)

Telephone No. (H) _____ (W) _____
(Area Code) (Area Code)

FINANCIAL INFORMATION

Will the Resident be paying for his/her care from their personal funds? Yes No If yes, then the resident must qualify financially.

Note: Federal and State laws provide severe penalties for obtaining Medicaid fraudulently. Being as accurate and complete as you can in this section, you are documenting exactly how to substantiate your request for Medicaid. Federal law prohibits the transfer of assets for a 36-month period (3 years) subsequent to Medicaid eligibility.

Savings or Checking Accounts:

	Bank(s)	Balance(s)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Real Estate:

Does the Resident own their home? Yes No Approximate Value \$ _____
 Does the Resident own any other property? Yes No Approximate Value \$ _____
 Location: _____

Life Insurance Cash Value:

Does the Resident have policies with cash value? Yes No Approximate Value \$ _____

Stocks / Bonds / Securities:

Does the Resident have stocks or bonds? Yes No Approximate Value \$ _____

If yes, Agent's Name _____ (Phone Number) _____

Other Income: (Monthly Average)

Pension / Social Security \$ _____
 Commissions / Annuities \$ _____
 Dividends / Interest \$ _____
 Rental / Real Estate Income \$ _____

Liabilities: (Monthly Average)

Notes Payable \$ _____
 Notes Payable \$ _____
 Other Liabilities \$ _____
 Other Liabilities \$ _____

AUTHORIZATION

Everything stated in this application is true and correct. I understand that Hillhaven will check my bank references and credit history and I authorize this. I also understand Hillhaven considers this application a continuing statement of financial condition and agree to notify Hillhaven in writing of any substantial change in the above financial condition. Hillhaven will keep all of this information strictly confidential. I agree that a photocopy shall have the full force and effect as this original application. This application must be completed to be considered for admission.

Signature of Resident _____ Date _____

Or

Signature of Agent _____ Date _____