



**APPLICATION FOR NURSING HOME RESIDENCY**  
Application will be kept on file for 12 months from receipt.

**Date:** \_\_\_\_\_  
 Immediate Need  
 Future Need

**I. GENERAL INFORMATION:**

Applicant's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current facility (if in a facility): \_\_\_\_\_

Place of birth: \_\_\_\_\_ Sex: \_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ US Citizen: Yes  No

Marital Status: \_\_\_\_\_ Veteran: Yes  No  Veteran # \_\_\_\_\_ Church Affiliation: \_\_\_\_\_

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_ Supplemental Insurance: \_\_\_\_\_

Does the applicant have additional long-term care insurance or any other insurance that would apply to nursing home care? Yes  No

Insurance Co. Name: \_\_\_\_\_ Recent hospitalization? Yes  No

Where: \_\_\_\_\_ Date Admitted: \_\_\_\_\_ Date Discharged: \_\_\_\_\_

Is there a history of mental illness or retardation? Yes  No  Diagnosis of dementia? Yes  No

Is the applicant currently on medication for the treatment of mental illness, e.g., depression, anxiety? Yes  No

Is the applicant currently on medication for treatment of insomnia? Yes  No

**Current Problem/Diagnosis:** \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**II. FAMILY INFORMATION**

Please Check:  Appointed Guardian  Durable Power of Attorney - Health Care

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship to applicant: \_\_\_\_\_

***If no Legal Guardian/Durable Power of Attorney - Health Care has been appointed, please list the person responsible for financial matters and health care decisions:***

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship to applicant: \_\_\_\_\_

**Please provide the following information on additional immediate family members:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship to applicant: \_\_\_\_\_

**Financial information will be requested prior to admission.**