

Carlisle Manor Health Care

APPLICATION FOR RESIDENCY

To apply for admission, please complete this questionnaire, and return it to the Mrs. Debbie Dillon, Admissions Director. All information will be held in confidence. A more complete medical history and physical exam will be recorded on another form. This application will become a part of the "Resident Agreement".

Name of Applicant: Mr. Mrs. Ms. _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone No: _____

Religion: _____ Church: _____

Date of Birth: _____ Place of Birth: _____ State: _____

Social Security No: _____ Marital Status: ___ Single ___ Married ___ Widowed
(Please attach a copy of the card)

Medicare No: _____ Effective Date: _____
(Please attach a copy of front and back of card)

Medicaid No: _____ Effective Date: _____
(Please attach a copy of the card)

Coinsurance Policy Co. & No: _____ Effective Date: _____
(Please attach a copy of front and back of card)

Funeral Home: _____ Prepaid: ___ Yes ___ No

Name of person completing this form: _____

Relationship to resident: _____ Telephone No: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about the Carlisle Manor?

____ Newspaper _____ Brochure _____ Friend
____ Social Worker _____ Physician _____ Hospital
____ Other Nursing Facility _____ Other

Have you visited any other nursing facilities? ___ Yes ___ No

If yes, which ones?

MEDICAL AND PERSONAL DATA

Diagnoses:

Resident's Current Physician: _____ Telephone No: _____

<input type="checkbox"/> Mentally Alert	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Confused
<input type="checkbox"/> Eats Independently	<input type="checkbox"/> Requires Help with Feeding	<input type="checkbox"/> Ambulatory
<input type="checkbox"/> Requires Special Diet	<input type="checkbox"/> Walks with Assistance	<input type="checkbox"/> Chair-Ridden
<input type="checkbox"/> Bed-Ridden	<input type="checkbox"/> Requires Bed Rails	<input type="checkbox"/> Continent
<input type="checkbox"/> Incontinent		

Admission Date desired: _____

Resident now residing at: _____

Reason for seeking admission: _____

I give permission for my (applicant's) doctor/hospital to release Medical Information

Name: _____ Signature: _____

The names(s) of the person(s) who will be financially responsible for the cost of the care (the "Guarantor")

Name(s): _____ Telephone No: _____

Address: _____ City: _____ State: _____ Zip: _____

Has a Trust Account been established? Yes No

If yes, please detail and attach a copy _____

Has a Durable Power of Attorney been appointed for financial affairs? Yes No

If yes, please attach a copy of the document.

Has a Legal Guardian been appointed? Yes No

If yes, please attach a copy of the guardianship papers.

Has a Living Will been executed? Yes No

If yes, please attach a copy of the document.

Has a Durable Medical Power of Attorney been appointed? Yes No

If yes, please attach a copy of the document.

FINANCIAL DATA

To process your application, the following information is needed. The information supplied is confidential and allows us to assist you in your long term financial planning. Your cooperation is appreciated in order to expedite the admission.

Monthly Income:

Salary	\$ _____
Social Security	\$ _____
Pensions/Annuities	\$ _____
IRA	\$ _____
Interest/Dividend	\$ _____
Rental Income	\$ _____
Investments/Other	\$ _____

Total: \$ _____

Assets/Description:

Account #:

Value:

Cash (please list bank names and account #'s):

		\$ _____
		\$ _____
		\$ _____

Securities (stocks bonds):

		\$ _____
		\$ _____

Real Estate (description and location): (Example: 3 bedroom house; Jones St., Anyplace OH 99999)

		\$ _____
		\$ _____

Other Assets:

Description:

Value:

Cash value of Life Insurance		\$ _____
Vested Pension Benefits		\$ _____
Business Interest		\$ _____
Automobiles		\$ _____
Other		\$ _____

Total Assets:

\$ _____

FINANCIAL DATA (Continued)

Liabilities:

Home Mortgage _____ \$ _____

Credit Cards/Charge Account _____ \$ _____

Loans _____ \$ _____

Other Debts _____ \$ _____

Taxes Owed _____ \$ _____

Total Liabilities: _____ \$ _____

NET WORTH (Assets - Liabilities): _____ \$ _____

Please sign below:

I hereby affirm that, to the best of my knowledge, the information provided on this application is accurate and complete.

Resident Signature _____ Date _____

Guarantor's Signature _____ Date _____

Reviewed by: _____
Director of Admissions _____ Date _____

Administrator _____ Date _____

Accounting _____ Date _____