STUDLEY HOME

RESIDENT APPLICATION

RESIDENT'S NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ BIRTHPLACE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOW LONG AT ABOVE ADDRESS? _____

CURRENT RESIDENCE (IF DIFFERENT FROM ABOVE): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ MEDICAID NUMBER: _____

MEDICARE NUMBER: _____ PART A: _____ PART B: _____

HEALTH INSURANCE CLAIM NUMBER: _____

SOURCE OF REFERRAL: _____ PHONE NUMBER: _____

MARITAL STATUS: _____ IF MARRIED, SPOUSE'S NAME: _____

SPOUSE'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S PHONE NUMBER: _____

CHILD/NEXT OF KIN: _____ RELATIONSHIP TO RESIDENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ (BUSINESS): _____

OCCUPATION: _____

WILL NEXT OF KIN BE AVAILABLE FOR TRANSPORTATION TO APPOINTMENTS, IF NEEDED? _____

If Resident is a DNR "do not resuscitate|DNR", please include documents to confirm that.

RESPONSIBLE PARTY | FAMILY MEMBER RESPONSIBLE FOR MANAGING RESIDENT'S AFFAIRS

NAME: _____ RELATIONSHIP TO RESIDENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ (BUSINESS): _____

OCCUPATION: _____

WILL THIS INDIVIDUAL HELP DEFRAY COST OF RESIDENTIAL CARE? _____

If legal guardian or holder of a power of attorney, please state and provide a copy of the power of attorney or a copy of the court order relative to guardianship.

MEDICAL INFORMATION CONCERNING PROSPECTIVE RESIDENT

PHYSICIAN'S NAME: _____ PHONE NUMBER: _____

PEASON FOR PLACEMENT: _____

ALLERGIES (FOOD, MEDICATION, ETC.): _____

PLEASE PROVIDE RESIDENT'S LIST OR A COPY OF THEIR CURRENT MEDICATIONS: _____

RESIDENT'S LAST HOSPITALIZATION: _____

HOW LONG: _____

FOR WHAT: _____

FINANCIAL AND LEGAL INFORMATION

RESIDENT'S NAME: _____ DATE: _____

DOES RESIDENT HAVE A DURABLE POWER OF ATTORNEY OR LIVING WILL? IF YES, WHO IS THE CUSTODIAN OF THIS INSTRUMENT? _____

_____

WILL THE RESIDENT PAY FOR STAY OUT OF THEIR OWN FUNDS? _____

HAS THE RESIDENT APPLIED OR WILL THE RESIDENT BE APPLYING FOR MEDICAL ASSISTANCE? _____

IF RESIDENT HAS APPLIED, WHAT WAS THE DATE? _____ WHERE? _____

All questions must be answered as completely and accurately as possible.

CASH ASSETS (PLEASE USE ADDITIONAL SHEETS IF NECESSARY)

BANK: _____

LOCATION: _____

TYPE OF ACCOUNT (SAVINGS, CHECKING, ETC.): _____

BALANCE IN ACCOUNT: _____

MONTHLY INCOME INFORMATION

SOCIAL SECURITY: _____

SUPPLEMENTARY SECURITY: _____

VA PENSION: _____

RETIREMENT PENSION: _____

TRUST FUND: _____

RENTAL: _____

OTHER: _____

OTHER ASSETS (PLEASE LIST OTHER ASSETS AND THEIR VALUE SUCH AS STOCKS, BONDS, LIFE INSURANCE WITH A CASH VALUE, ETC.)

LIFE INSURANCE: _____

ANNUITIES: _____

REAL ESTATE: _____

NET WORTH: _____

FINANCIAL INFORMATION CONCERNING SPONSOR

WILL RESPONSIBLE PARTY PAY FOR THE RESIDENT'S STAY? _____

WILL RESPONSIBLE PARTY USE RESIDENT'S ASSETS TOWARDS RESIDENT'S STAY? _____

If responsible party will pay for the Resident, then responsible party must answer questions as found in the financial and legal information section of this application.

FRAUD

Making false statements respecting a financial condition is against the law. State law has a penalty for a person found guilty of fraud.

AUTHORIZATION

I attest, under penalty of perjury, that everything stated in this application is true and correct. I understand that the Nursing Home will check my bank references and credit history and I authorize this. I also understand that the Nursing Home considers this application as a continuing statement of financial condition and I agree to notify the Nursing Home, in writing, of any substantial changes in the above financial condition. All of this information will be kept strictly confidential by the Nursing Home. I agree that a photocopy of this shall have the full force and effect as the original application.

DATE: _____ SIGNATURE OF RESIDENT: _____

DATE: _____ SIGNATURE OF RESPONSIBLE PARTY: _____

RESIDENT PREFERENCES AND PERSONALITY

DOES RESIDENT USUALLY LIKE TO BE DRESSED AND GROOMED PROPERLY? _____

HAIRDRESSER'S APPOINTMENTS? _____ HOW OFTEN? _____

CHECK IF DESCRIPTIVE OF RESIDENT

☐ ALERT ☐ BELLIGERENT ☐ COOPERATIVE ☐ COMBATIVE ☐ NOISY ☐ ORIENTED

☐ WITHDRAWN ☐ QUIET ☐ SOCIABLE ☐ DEPRESSED ☐ WEEPY ☐ FORGETFUL

☐ WANDERS ☐ VAGUE

DISORIENTED TO:

☐ TIME ☐ PLACE ☐ PERSON

ACCEPTS NEED FOR PLACEMENT? _____

_____

IS RELIGION AN IMPORTANT ASPECT OF RESIDENT'S LIFE? _____ IF YES, PLEASE EXPLAIN INVOLVEMENT: _____

_____

WOULD RESIDENT APPRECIATE ACTIVITIES? _____

LIST HOBBIES OR INTERESTS: _____

_____

_____

PLEASE USE THE REMAINING SPACE (OR ATTACH ANOTHER SHEET) TO TELL US ANYTHING ELSE WE SHOULD KNOW ABOUT THE RESIDENT

MOBILITY

DOES RESIDENT WALK REGULARLY? _____ IF YES, HOW FAR? _____

DO THEY REQUIRE ASSISTIVE DEVICES? ☐ WALKER ☐ CANE ☐ WHEELCHAIR ☐ OTHER ASSISTANCE

CAN RESIDENT TRANSFER INDEPENDENTLY OUT OF BED AND CHAIR WHEN TOILETING?

☐ REQUIRES ASSISTANCE WITH TRANSFERS ☐ CAN MANAGE TRANSFER ALONE

SKIN HEALTH

DOES RESIDENT HAVE ANY SKIN HEALTH ISSUES WE SHOULD BE AWARE OF?

☐ WOUNDS ☐ SKIN CARE REGIMINE OR CARE ☐ SKIN TEARS ☐ OTHER

FEET HEALTH

DOES RESIDENT SEE A PODIATRIST REGULARLY? _____ IF SO, WHAT IS RESIDENT BEING TREATED FOR? _____

DIETARY

FEEDS SELF: _____ FEEDER: _____ NEEDS ENCOURAGEMENT: _____

APPETITE (GOOD, FAIR, POOR): _____

WEIGHT: _____ NORMAL LIFETIME WEIGHT: _____ HEIGHT: _____

SPECIAL DIET: _____

FOOD LIKES AND DISLIKES: _____

_____

DESCRIBE USE OF ALCOHOL AND TOBACCO: _____

_____

DESCRIBE RESIDENT'S NEEDS IN THE FOLLOWING AREAS (T FOR TOTAL CARE, A FOR ASSISTANCE, I FOR INDEPENDENT)

BATHING _____ DRESSING _____ GROOMING _____

BOWEL (CONTINENT OR INCONTINENT) _____ BLADDER (CONTINENT, INCONTINENT, CATHETER) _____

HEARING (GOOD, POOR) _____ HEARING AID (YES | NO) _____

VISION (GOOD, POOR) _____ GLASSES (YES | NO) _____

LAST EYE EXAM: _____

DENTURES (UPPER, LOWER) _____ LAST DENTAL EXAM: _____

DOES RESIDENT USE OXYGEN? _____ HOW OFTEN? _____

SLEEPING PATTERN: ☐ SOUND SLEEPER ☐ UP AT NIGHT ☐ NAPS IN DAY