HIAWATHA CARE CENTER

405 N 15TH AVENUE
HIAWATHA, IOWA 52233
Phone (319)378-8583 Fax (319)378-8598
EMAIL: hccinfo@hcc.com

Nursing Facility

APPLICATION FOR RESIDENCY

Application Date_________________ Anticipated Admission Date____________________________

Name________________________________ Social Security Number _______ - _______ - ________

Address________________________ City___________________ State_______ Zip ____________

Date of Birth____________________ Gender______ Age________ Marital Status ____________

Lifetime Occupation_____________________________ Referred by __________________________

Medicare #____________________________Medicaid (T19)# _______________________________

Prescription Insurance Plan: __________________________ Policy # _________________________

Other Insurance:
Medicare Supplement:_________________________________ Policy # ________________________

Long-term Care Insurance: ____________________________ Policy # ________________________

Veterans? Y ___ N ___ Spouse of a Veteran? Y ___ N ___ Receiving VA Benefits? Y___ N ___

Emergency Contact:

Name_______________________________

Address_____________________________

____

Phone (H)___________________________

(W)___________________________

(C)___________________________

Email: ______________________________

Relationship _________________________

Billing Contact:

Name_______________________________

Address_____________________________

____

Phone (H)___________________________

(W)___________________________

(C)___________________________

Email: ______________________________

Relationship_________________________

Additional Contact:
Name________________________________
Address______________________________
____
Phone (H)____________________________
(W)____________________________
(C) ____________________________
Relationship__________________________

Additional Contact:
Name:________________________________
Address ______________________________
____
Phone (H) ____________________________
(W)____________________________
(C)____________________________
Relationship __________________________

ADVANCED DIRECTIVES

Financial P.O.A.____
Phone (H) ____________________ (W)______________________(C)_________________________
Durable P.O.A. for Healthcare____
Phone (H)____________________ (W) _____________________(C)_________________________
Living Will? Y___ N___
Religion Preference________________________ Church___________________________________
Clergy____ Phone________________________________
Attending Physician____________________________ Phone ________________________________
Address____
Dentist____ Phone________________________________
Address____
Eye Doctor_____________________________________ Phone________________________________
Address____
Podiatrist_____________________________________ Phone ________________________________
Address____
Pharmacy______________________________________ Phone________________________________
Address____
Hospital Preference___________________________ Phone ________________________________
Address____
Mortuary______________________________________ Phone ________________________________
Address____

CONFIDENTIAL FINANCIAL DATA (Required)

Assets		Monthly Income	
Checking account balance	$______________	Social security	$________________
Savings accounts	______________	Pension/Retirement	________________
Investments/CD's	______________	Rental income	________________
Stocks/bonds	______________	Investment income	________________
Real estate	______________	Other	________________
Other	______________		
Total Assets	$______________	Total monthly income	$_______________

MEDICAL INFORMATION

Current diagnosis____

____

History/past diagnoses____

____

____

Current medications:

______________________________ dose__________________ time(s)_________________________

______________________________ dose__________________ time(s)_________________________

______________________________ dose__________________ time(s)_________________________

______________________________ dose__________________ time(s)_________________________

______________________________ dose__________________ time(s)_________________________

______________________________ dose__________________ time(s)_________________________

Food / Drug allergies ____

____

Condition of sight ____

Condition of hearing ____

(Medical Information con't)

Check all that apply to current physical status:

___Mentally alert	___Ambulatory
___Forgetful	___Walks with assistance
___Confused	___Feeds self
___Continent of bladder	___Requires help with feeding
___Continent of bowels	___Special diet
___Bed-ridden	___Had one or more falls within last 30 days
___Chair-ridden	___Had one or more falls within last 30-180 days

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APPLICANT'S HISTORY

Please answer the following questions. This information will help us to make a more "home-like" living situation for your loved one.

1. Has the applicant been living alone? Yes____ No____

   If yes, for how long? ____________________________

2. During the past five years has the applicant

   ___ had a prior stay at this facility?

   ___ had a stay in another nursing home?

   ___ had a stay in another residential facility, board and care home, assisted living facility?

   ___ had a stay in a group home?

   ___ had a stay in a mental health facility (psychiatric setting)?

3. What is the highest level of education the applicant achieved?

___ No schooling	___ Technical or trade school
___ 8th grade or less	___ Some college
___ Some high school	___ Bachelor's degree
___ High school graduate	___ Graduate degree

4. Does applicant have a history of mental illness, retardation or development disability?

   Y__ N___

(Applicant's History con't)

5. What are the applicant's likes/dislikes/habits? (check all that apply)

   ___ Stays up late (after 9:00 p.m.)

   ___ Naps during the day

   ___ Goes out one or more days per week

   ___ Keeps busy with hobbies, reading or fixed daily routine

   ___ Spends most of time alone or watching TV

   ___ Uses tobacco products

   ___ Has distinct food preferences

   ___ Eats between meals

   ___ Uses alcoholic beverages at least weekly

   ___ Wakens to toilet during the night

   ___ Prefers showers

   ___ Prefers baths

   ___ Prefers a.m. shower/bath

   ___ Prefers p.m. shower/bath

   ___ Has daily contact with relative and/or friends

   ___ Usually attends church, temple or synagogue

   ___ Finds strength in faith

   ___ Involved in group activities

I declare that the above statements are true and accurate to the best of my knowledge.

____

Applicant/Responsible party

____

Date

For office use only:

Date received___________________________

S.O. Check: ________

Additional notes:

Revised 10/10/2008