PROMISE HOUSE

1320 LITCHFIELD AVENUE
HIAWATHA, IOWA 52233
Phone (319)743-9812 Fax (319)743-9815

APPLICATION FOR TENANT

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 # ________________________

Veteran? 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)____________________________

Relationship__________________________

Additional Contact:

Name:________________________________

Address ______________________________

____

Phone (H) ____________________________

(W) ____________________________

Relationship __________________________

ADVANCED DIRECTIVES

Financial P.O.A.____

Phone (H) ____________________________________ (W)___________________________________

Durable P.O.A. for Healthcare____

Phone (H)____________________________________ (W) ___________________________________

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___________________________

Additional notes:

Revised 8/11/2009