LaSalle County Nursing Home Application for Admission

Please Type or Print

Name_____ **Please Circle: M☐F☐**
Preferred Name or Nickname_____ **Please Circle: Mrs. Ms. Miss. Mr.**
Social Security Number_____ **Medicare Number**_____
Medicaid Recipient Number, if applicable: _____

Home Address: _____**City:** _____
Date of Birth: _____ **Age:** _____ **Place of Birth**_____
If foreign born: Date and Location of Naturalization: _____
How long have you resided at the residence listed above? _____
Father's Name: _____**Mother's Maiden Name:** _____
Marital Status: _____**Former Occupation:** _____
Military Service: Yes/No Dates of service: _____ **Branch of Military**_____
Spouse's Full Name: _____**If wife, her maiden name:** _____
Closest Living Relative_____ **Relationship** _____
Complete Address: _____**Phone Number:**_____

Name/Address of Healthcare POA:

_____

Name/Address of Financial POA:

_____

Other Children Name/Address/Phone:

_____
_____
_____
_____

Resident's Physician: _____**Address:**_____
Resident's Dentist_ _____ **Address:** _____
Religious Affiliation _____**Church/Parish Name:**_____
Upon admission, would you like us to contact your Clergyman: Yes: ☐ **No:** ☐

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Do you have a Durable Healthcare Power of Attorney? Yes:☐ No: ☐
If you answered "No", whom do you wish for us to notify in the event of and emergency?
Name: _____ Relationship: _____
Address: _____ Daytime Phone Number: _____
_____ Evening Phone Number: _____

Financial Information:

Present Means of Financial Support: _____
Name of Financial Institution: _____
Checking: ☐ Savings: ☐ CD's ☐ Stocks and Bonds: ☐

Have you the means of financial support during your stay at the nursing home?
Yes: ☐ No: ☐ Estimated number of Years? _____

Do you currently receive monthly monies from Social Security? Yes: ☐ No: ☐
If Yes, the current monthly amount: $ _____

Do you currently receive a monthly pension? Yes: ☐ No: ☐
If yes, the current monthly amount: $_____

Do you currently receive any monthly pension from a spouse? Yes: ☐ No: ☐
If yes, the current monthly amount: $ _____

Do you currently receive Public Aid (Medicaid) Assistance: Yes: ☐ No: ☐
If yes, the current monthly amount: $ _____

Do you currently carry Supplemental Insurance: Yes: ☐ No: ☐
If yes, please provide a copy of your insurance card to the Business Office and advise the office of any future changes as they occur.

Supplemental Insurance Carrier's Name: _____
Address: _____ Phone: _____
Agent's Name: _____ Agent's Phone: _____
Policy Number: _____

Do you currently have a Medicare Part D Prescription Drug Plan? Yes: ☐ No: ☐
If yes, please provide a copy of your insurance card to the Business Office and advise the office of any future changes as they occur.
Medicare Part D Insurance Carrier's Name, Address, and phone number:
_____
Policy Number: _____