

Hidden Meadows on the Ridge Admission Application

Full Name of Prospective Resident _____ **Date** _ _____

I. General Information

Current Residence _____

Current Phone Number (_____) _____

- Home of apartment, alone Home or apartment, with family/friends
 Home or apartment with home health, day services or other formal supports
 Another personal care facility (name): _____
 Nursing facility (name): _____
 Other (describe): _____

Assistance received at prior residence (medication administration, personal care assistance, transportation, financial assistance, etc): _____

Length of Time at Prior Residence (listed above)

- < 3 months 3 months – 1 year 1-5 years 5 or more years

Marital Status: Married Divorced Widowed Single Separated

Military Service: No Yes if yes, which Branch _____

Social Security Number _____

Eye Color _____ Hair Color _____ Height _____

Weight _____ Date of Birth _____ Age _____

How did you learn about us? (Please check all that apply)

- Friend Saw sign or building Internet Radio Newspaper
Physician Other _____

II. Emergency Contact Information:

Name of Emergency Contact _____

Relationship to Resident _____

Primary Phone Number _____

Alternative Phone number _____

Address _____

Email _____

Secondary Emergency Contact _____

(This person will only be called if first contact cannot be reached or is on vacation)

Relationship to Resident _____

Primary Phone Number _____

Alter. Phone number _____

Address _____

Email _____

III. Power of Attorney

Is someone authorized by a Power of Attorney to handle financial matters and / or make healthcare decisions for the Resident? Yes No

If yes, please give his or her name and address and provide us with a copy of the Power of Attorney.

Name _____ Primary Phone (____) _____

Address _____

Email Address _____

IV. Leisure Activities

What activities does the Potential Resident enjoy (such as hobbies or interests)?

Does the Potential resident like to socialize with other people? Yes No

Describe any situations or activities that are disturbing or agitating for the Potential Resident?

V. Medical History:

Primary Diagnosis: _____

Allergies: _____

Primary Care Physician _____ Phone Number _____
Fax Number _____

Other Physician's Name _____ Phone Number _____
Fax Number _____

_____ Phone Number _____
Fax Number _____

_____ Phone Number _____
Fax Number _____

Dentist's Name _____ Phone Number _____
Fax Number _____

Eye Doctor's Name _____ Phone Number _____
Fax Number _____

Preferred Hospital _____ Phone Number _____

What other medical issues should we be aware of?

Primary Medical Insurance & ID# (please submit copies of cards)

Other Supplemental Insurer _____ Policy or ID # _____

Does the potential resident have a Prescription Plan? Yes No

Does the potential resident have a Prescription Card? Yes No If yes, please provide us with a copy of the plan and / or card (both sides) to determine whether it can be honored.

Does the applicant have long-term care insurance? Yes No

If yes, provide carrier & policy or ID # _____

Does the potential resident have a living will? Yes No
If yes, please provide a copy with this application.

VI. Ambulation

Does the potential resident need any of the following? (Please circle all required)
Wheel Chair Cane Walker

Does the potential resident need help getting in and out of bed? Yes No

Please list any recent falls or other safety issues:

VII. Personal Care

Does the potential resident need help with any of the following? (Please check yes or no for all that apply)

Dressing/Undressed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Showering	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hair Care	<input type="checkbox"/>	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	Shaving	<input type="checkbox"/>	<input type="checkbox"/>

Is the potential resident continent of Bowel? Yes No
Is the potential resident continent of Bladder? Yes No

VIII. Dining & Eating

Does the potential resident have any food allergies? Yes No
If yes, please list them: _____

Is the potential resident on any special diet? Yes No
If yes, please list needs: _____

Is the potential resident aware of appropriate foods to eat for special diet? Yes No

Does the resident have the following? Dentures Partial Real Teeth

Does the potential resident have trouble chewing food? Yes No

Does the potential resident have trouble swallowing? Yes No

What assistance does the potential resident need in the dining room?

IX. Religious Preference

Religious Preference (if any) _____

Name of Church or Synagogue _____

Name of Clergy, if known _____

X. Financial and Billing Information

Monthly invoices for services are to be mailed to the following person:

Name _____ Primary Phone (_____) _____

Address _____

Email _____

XI. Funeral Information

Name of Funeral Director/Parlor _____

Phone Number/ Address _____

By my signature below, I certify that the information contained in this application for residency is accurate and complete to the best of my knowledge.

Applicant's Signature

Date

Power of Attorney's Signature

Date

*Please submit your admission application along with your financial questionnaire, MA-55 & Addendum. The admissions committee will review your paperwork and contact you about the decision on the eligibility for admission.