

REQUIREMENTS FOR ADMISSION

1. *Complete application and financial forms.*
2. *Provide the necessary medical information.*

A. Admission from a hospital or another nursing facility

1) Information below is supplied by Social Worker/Case Manager at hospital following request from the Admissions Coordinator

- History and Physical*
- Nurses' progress notes*
- Chest X-ray, Lab screening results*
- List of Medications*

B. Admission from a private residence

- 1) Pre-admission medical form completed by applicant's physician*
- 2) Assessment form completed by a family member*
- 3) Interview of applicant by a member of the St. Joseph Villa nursing staff*

3. *The Admissions Committee will make a decision concerning admission based on the above information.*
4. *Copies of the following must accompany the application form:*
 - A. One copy of Medicare/Social Security, secondary insurance, PACE (if applicable), Medicare- D Prescription Plan cards*
 - D. Durable Power of Attorney for Health Decisions and/or Living Will*

ALL MEDICATIONS are procured from the pharmacy with whom we have contracted. Only bring medications for the nurse to see. Do not procure any refills of medication before admission. ALL MEDICATIONS INCLUDE OVER-THE-COUNTER PURCHASES as well.

**SAINT JOSEPH VILLA
APPLICATION FOR ADMISSION**

Applicant's Name _____ *Date of Birth* _____

Address _____ *Marital Status* _____

Religion _____
Telephone Number _____
City _____ *State* _____ *Zip Code* _____

Applicant's lifetime occupation _____

Social Security Number _____

Applicant is currently at _____ *Date Admitted* _____

Applicant's physician _____ *Physician's Phone* _____

Responsible Party for billing purposes only

Name _____ *Relationship* _____

Address (for billing purposes) _____ *Home Phone* _____

City _____ *State* _____ *Zip Code* _____ *Cell or Business Phone* _____

Second Contact _____ *Relationship* _____

Home Phone _____ *Cell or Business Phone* _____

MEDICAL INSURANCE

Please check Medicare A *Yes* _____ *Medicare ID#* _____
Medicare Part B ONLY *Yes* _____ *No* _____

Primary Insurance (if NOT Medicare) _____
ID# _____ *Group#* _____

Secondary Insurance Company _____
ID# _____ *Group#* _____

PRESCRIPTION PLAN

PACE Number (if applicable) _____
Medicare D (if applicable) _____

Other Prescription Plan _____

List residency of applicant in any Hospitals or Medical/Psych Institutions during the past three years

<u>PLACE</u>	<u>DATE(S)</u>	<u>REASONS FOR HOSPITALIZATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Doctor/Primary Care Physician Name _____
Address _____
City _____ State _____ Zip Code _____
Telephone Number _____

If above physician has been the Primary physician for fewer than the last two years, please list information of previous PCP _____

Name _____
Address _____
City _____ State _____ Zip Code _____
Telephone Number _____

Diet _____

Known Allergies _____

Does the applicant have a Power of Attorney and/or Living Will? YES _____ NO _____

Do you anticipate a short-term (recuperative) stay? YES _____ NO _____

Do you anticipate an indefinite stay? YES _____ NO _____

If you do not anticipate an indefinite stay, what plans to you have for the resident at the time of discharge? _____

Laundry to be done by: (please check) Facility _____ Family _____

Funeral Director Name _____
Address _____

City _____ State _____ Zip Code _____
Telephone Number _____

SAINT JOSEPH VILLA

FINANCIAL DATA

Name of Applicant _____

PRESENT MONTHLY INCOME

Source _____ \$ _____ /*Month*
Source _____ \$ _____ /*Month*
Source _____ \$ _____ /*Month*
Source _____ \$ _____ /*Month*

ASSETS (Please include a separate sheet for any additional accounts.)

SAVINGS ACCOUNT

Bank _____ *Account#* _____
Bank Location _____ *Amount* _____
Jointly Owned? _____ *Yes* _____ *No* _____
If YES, with whom? _____

CHECKING ACCOUNT

Bank _____ *Account#* _____
Bank Location _____ *Amount* _____
Jointly Owned? _____ *Yes* _____ *No* _____
If YES, with whom? _____

N.B. Please include a copy of bank statements for all accounts. This applies to ALL ADMISSIONS (short-term admission, respite stay, and long-term admission.)

STOCKS/BONDS Yes _____ Amount _____ No _____

CERTIFICATES OF DEPOSIT Yes _____ Amount _____ No _____

REAL ESTATE Yes _____ Amount _____ No _____

OTHER Yes _____ Amount _____ No _____

LIFE INSURANCE POLICIES (Any additional policies, please use a separate sheet.)

Company _____

Beneficiary _____

Who is holding this policy? _____

Does the applicant have a pre-paid burial fund? Yes _____ No _____

Does the applicant have an irrevocable bank account for burial? Yes _____ No _____

LIABILITIES

Mortgages Yes _____ No _____

Liens Yes _____ No _____

Outstanding Debts Yes _____ No _____ If yes, amount outstanding \$ _____

WILL

Lawyer/Executor _____

Power of Attorney _____

DAILY RATES

Second Floor (skilled nursing care) _____ @ day

Third Floor (intermediate/custodial care) _____ @ day

Saint Joseph Villa
PRE-ADMISSION MEDICAL FORM

Name of Applicant _____ Date of Birth _____

Address _____ Telephone _____

Primary Care Physician _____ Telephone _____

Signature of Physician completing this form _____

Total number of years applicant has been under your care _____

Diagnoses: _____

Medications: _____

Treatments: _____

Medical History: _____

Please complete Page 2 (Systems Review)

SYSTEMS REVIEW

Please check where appropriate—

MENTAL STATUS

alert _____
 cooperative _____
 calm _____
 lethargic _____
 withdrawn _____
 depressed _____
 agitated _____
 anxious _____
 combative _____
 wanderer _____
Oriented to:
 time _____
 place _____
 person _____

SPEECH

normal, clear _____
 slurred _____
 hesitant _____
 hoarse _____
 dysphasic _____

NEUROLOGIC SYSTEM

normal _____
 pupils: PERRLA _____
 dizziness _____
 numbness _____
 headaches _____
 paraplegia _____
 hemiplegia, left _____
 hemiplegia, right _____
 Comments _____

GI SYSTEM

normal _____
 change in appetite _____
 indigestion _____
 bleeding _____
 nausea _____
 vomiting _____
 abdominal distention _____
 ascites _____
 hemorrhoids _____
 constipation _____
 diarrhea _____
 incontinent _____
Bowel sounds
 present _____
 absent _____

NUTRITIONAL STATUS

special diet _____
 recent weight loss _____
 recent weight gain _____

EYES

normal _____
 glasses _____
 contact lenses _____
 implanted lenses _____
 blind _____
 artificial prosthesis _____
 discharge _____
 double vision _____
 blurred vision _____
 tearing _____
 burning _____
 itching _____
 pain _____
 cataract _____
 sclera color _____

EARS

normal _____
 hearing loss _____
 hearing aid _____
 tinnitus _____
 Vertigo _____
 discharge _____
 pain _____

NOSE

normal _____
 sinusitis _____
 rhinitis _____
 discharge _____
 obstruction _____
 Epistaxis _____

REPRODUCTIVE SYSTEM

Female:
 irregular bleeding _____
 discharge _____
 vaginal infections _____
 menopause _____
 other _____
Male:
 lesions _____
 prostate problems _____
 other _____

MUSCULOSKELETAL SYSTEM

normal _____
 stiffness _____
 pain _____
 weakness _____
 limited ROM _____
 arthritis _____
 physical activity _____
 no limitations _____
 walks with help _____
 bedridden _____
 Falls _____
 Walker/cane/wheelchair _____

MOUTH AND THROAT

normal _____
 dentures, upper _____
 dentures, lower _____
 partial plate _____
 dental fillings _____
 broken teeth _____
 missing teeth _____
 mouth sores _____

RESPIRATORY SYSTEM

normal _____
 dyspnea _____
 cough _____
 hemoptysis _____
 pain _____
 orthopnea _____
 breath sounds _____

CARDIOVASCULAR SYSTEM

normal _____
 edema _____
 cyanosis _____
 palpitations _____
Extremities:
 regular _____
 irregular _____
 bounding _____
 weak _____
 thready _____
 pedal pulse, right _____
 pedal pulse, left _____

SKIN

rash _____
 bruises _____
 burns _____
 lumps _____
 lacerations _____
 abrasions _____
 scars _____
 pressure ulcers _____

SOCIAL HISTORY

tobacco — _____
 packs@day _____
 alcohol — _____
 Drinks@day/@wk _____

GU SYSTEM

Normal _____
 frequency _____
 urgency _____
 dysuria _____
 nocturia _____
 incontinent _____
 bleeding _____
 burning _____