

**FOUNTAIN SPRINGS HEALTH CARE
APPLICATION FOR ADMISSION**

Date _____

I. **HOW DID YOU LEARN ABOUT US?** _____
_____II. **GENERAL INFORMATION CONCERNING PROSPECTIVE RESIDENT****A. Background Information**Resident's Name _____ Age _____ DOB _____ Sex _____
(Name Preference _____)

Home Address _____ Telephone No. _____

City _____ State _____ Zip _____

Resident is now at (Home) ___ (Hospital) ___ (Nursing Home) ___ Other (List) _____

Identify institution if applicable: Name _____

Address _____

City _____

Telephone No. _____ How Long _____

Resident's Social Security No. _____ Medicare No. _____

Does Resident have long term care insurance, Medicaid, or any other insurance that will cover

Nursing Home Care? Yes _____ No _____

If yes, please identify: Company _____

Policy Number _____

Agent's Name _____ Telephone No. _____

Medicaid # _____, if Pending Medicaid, give date
applied _____.

Does Resident have a personal physician? Yes _____ No _____

If yes, please identify: Physician's Name _____

Address _____

Telephone Number _____

Will physician attend here? Yes _____ No _____

Inquirer _____ Relationship to Resident _____

Telephone No. (Home) _____ (Work) _____

Spouse:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. (Home) _____ (Business) _____

Occupation _____ Deceased / Living

Living or Deceased Children:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. (Home) _____ (Business) _____

Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. (Home) _____ (Business) _____
Occupation _____ \ Deceased or Living

B. Sponsor and/or family member responsible for paying bill.

Name _____ Relationship to Resident _____
 Legal Guardian _____ DPOA _____
 Home Address _____
 City _____ State _____ Zip _____
 Telephone No. (Home) _____ (Business) _____
 Occupation _____

III. MEDICAL INFORMATION CONCERNING PROSPECTIVE RESIDENT

A. Current problem/diagnosis: _____

Medications presently taking: _____

How long has this problem existed? _____

Resident's last hospitalization: Dates _____

For what? _____

Has the Resident ever been in another Nursing Home? Yes _____ No _____

Dates? _____ Name of Nursing Home(s)? _____

Why did Resident leave the Nursing Home? _____

B. Resident's Special Needs:

Grooming, needs assistance? Yes _____ No _____ Dressing, needs assistance? Yes _____ No _____

Bathing, needs assistance? Yes _____ No _____ Eating, needs assistance? Yes _____ No _____

Special diet? Yes _____, what and why _____ No _____

Special skin care? Yes _____, Explain: _____ No _____

Is Resident incontinent? Yes _____ No _____ (Bowel _____ Bladder _____ Both _____)

Is Resident's eyesight good? Yes _____ No _____

Does the Resident wear glasses? Yes _____ No _____ When was last eye exam? _____

Is Resident's hearing good? Yes _____ No _____, Explain: _____

Hearing Aides? Right _____ Left _____

Date of last Tuberculin skin test: _____

Does the Resident wear dentures? Yes _____, upper _____ lower _____ partial _____ No _____

When was last dental/gum exam? _____

Does Resident need: Oxygen _____ Catheter _____ Respirator _____ Tube Feeding _____

Does Resident have: Colostomy/Ileostomy _____ Prosthesis _____ If so, what? _____

Resident's physical mobility:

Walks unassisted _____ Uses wheelchair _____, assisted _____ unassisted _____

Walks only with assistance _____ Uses walker _____ Bed-bound _____ Cane _____

Does Resident have any other problems that require special care and attention? Yes _____ No _____

If yes, please describe: _____

C. Resident's Mental Status

Is Resident competent? Yes _____ No _____ **OR** Incompetent per doctor's order? Yes _____ No _____

If yes, please explain: _____

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Does the Resident usually desire to be dressed and groomed properly? Yes _____ No _____

If no, explain: _____

Does the Resident show any signs of unusual or bizarre behavior? Yes _____ No _____

If yes, please describe: _____

Is the Resident alert and cooperative? Yes _____ No _____, Explain: _____

Is the Resident quiet and controlled? Yes _____ No _____, Explain: _____

Is the Resident noisy and combative? Yes _____, Explain: _____ No _____

If Yes, does the applicant take medication for this condition? Yes _____ No _____

Does the Resident have episodes of crying, screaming, and yelling? Yes _____ No _____

Does the Resident have violent outbursts of temper? Yes _____, Explain: _____ No _____

Does the Resident generally get along with others? Yes _____ No _____, Explain: _____

Does the Resident like to converse and socialize with others? Yes _____ No _____, Explain: _____

Language(s) spoken: English _____ Other(s): _____

Does the Resident enjoy activities away from the facility? Yes _____, Explain: _____ No _____

Does the Resident tend to be depressed and withdrawn? Yes _____, Explain: _____ No _____

Has the Resident ever been diagnosed as mentally ill? Yes _____, Explain: _____ No _____

Describe any other significant event or occurrence you remember about the Resident's mental condition: _____

IV. Would Resident want:

A. Rapid City Journal? Yes _____ No _____

Family will make the arrangements for the Journal? Yes _____ No _____

Telephone service? Yes _____ No _____

Family will make the arrangements for the telephone service? Yes _____ No _____

Trust account? Yes _____ No _____

Family will make the arrangements for the trust account? Yes _____ No _____

V. Rate and Payment

A. Room Rate _____ for _____ room.

Payment Source: Private / T-19 Medicaid / Private Insurance

Expected Admit Date: _____ Time: _____
PAA Complete? Yes _____ No _____ PASARR Complete? Yes _____ No _____

Application reviewed and approved by: DON _____ Admin. _____ SSD _____

Date Admitted: _____ Time: _____ Admin. # _____ Room # _____

THIS APPLICATION MUST BE COMPLETELY FILLED OUT AND VERIFIED BEFORE RESIDENT WILL BE CONSIDERED FOR ADMISSION.

Where born: _____

Religion Pref.: _____

Education: _____

Mortuary Pref.: _____

Marital Status: _____

Military: _____

Parents Names: _____

Sibling Names: _____

Past Occupations: _____

Contacts if Emergency: #1 _____ Phone #: _____

#2 _____ Phone #: _____

#3 _____ Phone #: _____

Social Interests: _____

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