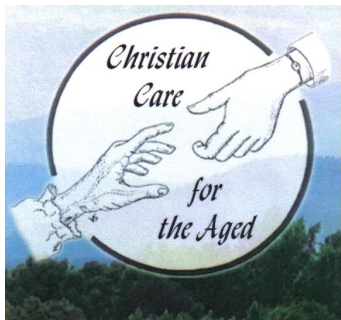


# APPLICATION FOR ADMISSION



*Mountain View Nursing Home*

1776 Elly Rd.

Aroda, VA 22709

Phone: 540.948.6831 \* Fax: 540.948.5402

Application Date: \_\_\_\_\_

Admission Requested:  Now  As future health requires

## Personal Information:

Name of Applicant \_\_\_\_\_

Last

First

Middle Initial

Date of Birth \_\_\_\_\_

Sex:  Male  Female

Full Address \_\_\_\_\_

Status:  Single  Married  Widowed  Divorced  Separated

Social Security No. \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Number of living children \_\_\_\_\_

Former Occupation \_\_\_\_\_

Present Interests \_\_\_\_\_

Church Affiliation, if any \_\_\_\_\_

Pastor's Name \_\_\_\_\_ Phone \_\_\_\_\_

## Medical Information:

Is applicant on Medicaid?  Yes  No If not, do they anticipate Medicaid within 12 months? \_\_\_\_\_

Medicare No. \_\_\_\_\_ Medicaid No. \_\_\_\_\_

Medicare D. No. \_\_\_\_\_ Prescription Plan \_\_\_\_\_

Long Term Care Insurance No. \_\_\_\_\_ Other \_\_\_\_\_

Present Physician \_\_\_\_\_ Phone \_\_\_\_\_

Has applicant been in a nursing home or hospital in the past year?  Yes  No

If yes, please list the facility and date admitted \_\_\_\_\_

Applicant is presently at:  Home  Home for Adults  Nursing Home  Hospital  Other \_\_\_\_\_

Describe applicant's general health condition by checking all that apply:

<i>Mental Alertness</i>	<i>Mobility</i>	<i>Elimination</i>	<i>Dietary</i>	<i>Other</i>
<input type="checkbox"/> Mentally alert	<input type="checkbox"/> Wanders	<input type="checkbox"/> Fully continent	<input type="checkbox"/> Feeds self	<input type="checkbox"/> Amputee
<input type="checkbox"/> Slightly forgetful	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Requires help	<input type="checkbox"/> Bed sores
<input type="checkbox"/> Confused/Dementia	<input type="checkbox"/> Walks with assistance	<input type="checkbox"/> Catheter	<input type="checkbox"/> Tube feeding	<input type="checkbox"/> Oxygen required
<input type="checkbox"/> Alzheimer's symptoms	<input type="checkbox"/> Non-ambulatory	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Diabetic	
<input type="checkbox"/> Combative/Aggressive	<input type="checkbox"/> Paralysis		<input type="checkbox"/> Special diet _____	

Applicant's approximate weight \_\_\_\_\_

Has applicant fallen in the past 6 months?  Yes  No If yes, how often? \_\_\_\_\_

Has applicant had a communicable disease within the past two years (e.g.: TB, Antibiotic Resistant Infection, MRSA, VRE, Hepatitis B, etc.):  Yes  No If yes, please describe \_\_\_\_\_

Other medical information or diagnoses \_\_\_\_\_

**Responsible Party:**

If applicant needs assistance in decision making, who will serve as the responsible party, guardian or Power of Attorney?

Name \_\_\_\_\_ Title \_\_\_\_\_

Have all family members given consent to this arrangement? \_\_\_\_\_

First Contact/Responsible Party:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Second Contact:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Does applicant have a Living Will/Advance Directives?  Yes  No If not, do they wish to do so? \_\_\_\_\_

*Medical treatment decisions will be discussed and addressed on admission.*

The sponsoring church has chosen to not have television and we maintain a smoke free environment.

Would either of these pose a problem?  Yes  No Comments \_\_\_\_\_

Signature of responsible party \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

*As soon as this completed application is returned to Mountain View Nursing Home, the applicant is placed on the waiting list.*