LINN · MANOR CareCENTER

1140 Elim Drive, Marion, Iowa 52302
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Nursing Facility
Application for Residency

Date Received: _____

Application Date: _____ Anticipated Admission Date: _____

Name: _____ Nickname: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: _____ Age: _____ Marital Status: _____

Lifetime Occupation: _____ Referred by: _____

Medicare # _____ Medicaid (T19) # _____

Prescription Insurance Plan: _____ Policy #: _____

Medicare Supplement: _____ Policy #: _____

Long-term Care Insurance: _____ Policy #: _____

Veteran? Y ____ N ____ Spouse of Veteran? Y _____ N _____ Receiving VA Benefits? Y _____ N _____

Contact Information

Emergency Contact: _____

Name: _____

Address: _____

_____

Phone: H: _____

W: _____

C: _____

Email: _____

Relationship: _____

Billing Contact:

Name: _____

Address: _____

_____

Phone: H: _____

W: _____

C: _____

Email: _____

Relationship: _____

Additional Contact: _____

Name: _____

Address: _____

_____

Phone: H: _____

W: _____

C: _____

Email: _____

Relationship: _____

Additional Contact:

Name: _____

Address: _____

_____

Phone: H: _____

W: _____

C: _____

Email: _____

Relationship: _____

Advanced Directives

Financial P.O.A. : _____

Phone : H: _____ W: _____ C: _____

Durable P.O.A. for Healthcare: _____ Please provide LMCC with a copy of this Document

Phone : H: _____ W: _____ C: _____

Religion Preference: _____ Church: _____

Clergy: _____ Phone: _____

Attending Physician: _____

Address: _____ Phone: _____

Dentist: _____

Address: _____ Phone: _____

Eye Doctor: _____

Address: _____ Phone: _____

Podiatrist: _____

Address: _____ Phone: _____

Pharmacy: _____

Address: _____ Phone: _____

Hospital Preference: _____

Address: _____ Phone: _____

Mortuary: _____

Address: _____ Phone: _____

Living Will: Y ____ N ____ Please provide LMCC with a copy of this Document

Cardiopulmonary Resuscitation (CPR): Y ____ N ____

Use of Respirators or Ventilators: Y ____ N ____

Blood Transfusions: Y ____ N ____

Tube Feeding: Y ____ N ____

Admission to Hospital: Y ____ N ____

Medical Information

Current Diagnosis: _____

_____

_____

_____

History/Past Diagnosis: _____

_____

_____

_____

Current Medications:

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

_____ dose _____ time(s) _____

Food/Drug Allergies: _____

_____

Condition of Sight: _____

Condition of Hearing: _____

Check all that apply to current physical status:

_____ Mentally alert

_____ Forgetful

_____ Confused

_____ Continent of bladder

_____ Continent of bowels

_____ Bed-ridden

_____ Chair-ridden

_____ Ambulatory

_____ Walks with assistance

_____ Feeds Self

_____ Requires help with feeding

_____ Special diet

_____ Had one or more falls within last 30 days

_____ Had one or more falls within last 30-180 days

Applicant's History

Please answer the following questions. This information will help us to make a more "home-like" living situation for your loved one.

Has the applicant been living alone? Y _____ N _____ If yes, for how long? _____

During the past five years has the applicant:

_____ had a prior stay at this facility?

_____ had a stay in another nursing home?

_____ had a stay in another residential facility, board and care home, assisted living facility?

_____ had a stay in a group home?

_____ had a stay in a mental health facility (psychiatric setting)?

What are the applicant's likes/dislikes/habits? (Check all that apply)

_____ Stays up late (after 9:00 pm)

_____ Naps during the day

_____ Goes out one or more days per week

_____ Keeps busy with hobbies, reading, or fixed daily routine

_____ Spends most of time alone or watching TV

_____ Uses tobacco products

_____ Has distinct food preferences

_____ Eats between meals

_____ Uses alcoholic beverages at least weekly

_____ Wakens to toilet during the night

_____ Prefers showers

_____ Prefers baths

_____ Prefers a.m. shower/bath

_____ Prefers p.m. shower/bath

_____ Has daily contact with relative and/or friends

_____ Usually attends church, temple or synagogue

_____ Finds strength in faith

_____ Involved in group activities

Confidential Financial Data

Assets		**Monthly Income**	
Checking Account Balance:	$	Social Security:	$
Savings Account Balance:	$	Pension/Retirement:	$
Investments/CDs:	$	Rental Income:	$
Stocks/Bonds:	$	Investment Income:	$
Real Estate:	$	Other:	$
Other:	$	Total Monthly Income:	$
Total Assets:	$		

I declare that the above statements are true and accurate to the best of my knowledge.

_____
Applicant/Responsible party

_____
Date

Revised 1/5/12