APPLICATION FOR NURSING HOME ADMISSION

The following is an application for admission to our facility. Whether your anticipated stay is planned for short-term or long-term we ask you to please complete this application and return it to the Admissions Director. Criteria for admission are the same for all persons without regard to race, gender, color, creed, religion, national origin, age, marital status, physical or mental impairments or source of payment.

Date: _____

Applicant's Name: _____

Maiden Name/Alias: _____

Date of Birth: _____

Age: _____

Place of Birth: _____

Gender: Female Male

Present Address: _____

Telephone number _____

Marital status: Married Divorced Separated Widowed Single

Spouse Name_____

Contact Information:

Primary contact/ Guarantor (person who is responsible for bills and signing documents)

Primary contact name: _____

Address: _____

Telephone number: _____

Relationship to applicant:

_____

Name of Employer: _____

Address and Telephone number: _____

Social Security Number or TRN Number: _____

Identification number _____

Country of Issuance _____

Does applicant have a Durable Power of Attorney? Yes No

Is this person listed above as the primary contact? Yes No

Does applicant have a Court appointed Legal Guardian? Yes No

If yes, please provide their contact information below:

Name: _____

Phone: _____

Address: _____

Secondary contact name: _____

Relationship to applicant: _____

Address: _____

Phone: _____

Person responsible for payments: Yes NO

Third contact name: _____

Relationship to applicant: _____

Address: _____

Phone: _____

Person responsible for payments: Yes NO

STAY

Please indicate applicant's anticipated stay:

Short Term Rehabilitation Long Term Placement

Please provide a brief description of the applicant's medical needs and the reason for placement:

Is applicant in need of immediate placement? Yes No

Did applicant have any type of surgery? Yes No

(For rehabilitation and post-op applicants only)

If yes, please provide a brief details pertaining to surgery type:

_____

_____

Name of hospital where surgery was performed: _____

Date applicant was admitted to the hospital: _____

Date applicant was discharged from the hospital: _____

Primary Care Physician Name: _____

Address and telephone: _____

Date of last visit: _____

Did applicant utilize any hospital services within the past two years? Yes No

If yes, name of Hospital(s): _____

Reason(s) for service:

_____

_____

Has applicant been in any other Nursing Home, Rehab Facility or Assisted Living within the past year?

Yes No

If yes, please provide the name and dates of service at facility/facilities?

Does applicant have a pre-paid burial contract? Yes No

If yes, name of Funeral Home where arrangements were made: _____

Does applicant have a living will or advance health care directive? Yes No

(If yes, please provide a copy)

PAYMENT

Account of: Tyra Channer, The Bank of Nova Scotia Jamaica Limited, Account # 901075, Montego Bay - Sam Sharpe Square Branch, Montego Bay, St James

I understand that this application should be completed in its entirety. I also understand that after acceptance for admission, a physical examination by the applicant's primary care physician or doctors providing care at the hospital is required. I give permission for the Admissions Director or facility designated staff person to contact me, my responsible party, or hospital worker for the purpose of acquiring further information. I affirm that the information provided is accurate and complete.

Applicant's Signature: Date:

Signature of Applicants Responsible Party (if applicable): Date: