Woodside Hall, LLC

Phone: 607-547-0600 / Fax: 607-547-0601

PRE-ADMISSION APPLICATION

Today's date: _____

PERSONAL INFORMATION

Name: _____ Phone: _____

Present Address: _____ _____ _____ _____
Street City State Zip code

Birth Date: _____/_____/_____ Present Age: _____

Marital Status: _____ Religion: _____

My occupation has been: _____

My hobbies and interests: _____

My representative: _____

Phone: _____ Email: _____

Representative's Address: _____ _____ _____ _____
Street City State Zip Code

FINANCIAL RESOURCES

Social Security #:_____-_____-_____ Work Income: _____

SSI: _____ Pensions/Other Income: _____

VA: _____ Total Monthly Income: _____

Other Income: _____ Life Insurance: _____

HEALTH INSURANCE INFORMATION

Primary Care Physician: _____ Preferred Hospital: _____

Optometrist: _____ Dentist: _____

Medicare: _____ Medicaid: _____

Prescription Plan: _____ Dental Insurance: _____

Vision Insurance: _____ Preferred Pharmacy: _____

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PRE-ADMISSION INTERVIEW

PRE-ADMISSION INTERVIEW INFORMATION	
Name:	Expected move in Date:
Interviewed by:	Current Date:

Medical Evaluation: Examination signed and submitted within 30 days prior to admission:

Mental Health Evaluation: Examination signed and submitted within 30 days prior to admission:

TB Testing: Tested, checked and submitted within 30 days prior to admission:

PLEASE RATE THE APPLICANTS NEEDS AND HOW THE FACILITY CAN MEET THESE NEEDS					
	1 = Poor	2 = Fair	3 = Satisfactory	4 = Good	5 = Excellent
Ambulation	☐	☐	☐	☐	☐
Comments: (wheelchair, cane, assistance?)					
Bathing	☐	☐	☐	☐	☐
Comments:					
Dressing	☐	☐	☐	☐	☐
Comments:					
Toileting	☐	☐	☐	☐	☐
Comments:					
Eating	☐	☐	☐	☐	☐
Comments:					
Medication Management	☐	☐	☐	☐	☐
Comments:					
Dietary Needs & Preferences	☐	☐	☐	☐	☐
Comments:					
Medical needs, including health services required by outside agencies:					
Financial Management Needs:					
Tracking Device in use: Yes No **If yes, provide monitoring information:**					

INTERVIEW SUMMARY
ADDITIONAL COMMENTS
GOALS *(improve ambulation, etc)*

VERIFICATION OF REVIEW	
By signing this form, you confirm that you have discussed this interview in detail with our representative.	
Applicant Signature:	Date:
WH Representative Signature:	Date:

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Information and Referral Intake

Date: _____

Name of Participant: _____

Date of Birth: _____

Address: _____

_____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Referral from: _____

Referral Phone: (____) _____ - _____

Emergency Contact Name: _____

Address: _____

_____

Contact Numbers:

Home: _____ **Work:** _____ **Cell:** _____

Is the participant a private referral?_____Or LTHHCP Referral _____ (check one)

Information Sent?: Yes____ No____ (If yes, date when sent) _____

Payment Source (Medicaid or Private Pay): _____

Is transportation Needed?_____

What did potential participant like to do when they were younger? _____

_____

Comments: _____

_____

_____

Admitted to Program? Y/N: _____

WH, LLC Staff Signature: _____ **Date:** _____